SERFF Tracking Number:	*MTLC-128335519*	*State:*	*Arkansas*
Filing Company:	*MTL Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*6300-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2012 Applications*		
Project Name/Number:	*/*		

Filing at a Glance

Company: MTL Insurance Company

Product Name: 2012 Applications	SERFF Tr Num: MTLC-128335519	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: L08.000 Life - Other	Co Tr Num: 6300-12	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Jamie Jensson	Disposition Date: 05/31/2012
	Date Submitted: 05/08/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 05/31/2012
	State Status Changed: 05/10/2012
Deemer Date:	Created By: Jamie Jensson
Submitted By: Jamie Jensson	Corresponding Filing Tracking Number:

Filing Description:

Form 2752-12 is our Policy Reinstatement application. This will replace Form 2752-11, previously approved on 08/10/2011

Form 6300-12 is our application for Life Insurance. This will replace Form 6300-11, previously approved on 08/10/2011

Form 6328-12 is our Policy Term Conversion/Purchase Option application. This will replace Form 6328-11, previously approved on 8/10/2011

Form 6329-12 is our Policy Reissue/Change application. This will replace Form 6329-11, previously approved on 08/10/2011

SERFF Tracking Number:	*MTLC-128335519*	*State:*	*Arkansas*
Filing Company:	*MTL Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*6300-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2012 Applications*		
Project Name/Number:	*/*		

Form 6330-12 is Part II of our Life application. This application will replace form 6330-09, previously approved on 01/04/2010

Form 6331-12 is our Policy Reissue/Change Supplemental application. This will replace Form 6331-11, previously approved on 08/10/2011

The above applications will be used with all of our life products, including whole life, term life, and universal life. The applications are intended for use on paper only.
State Narrative:

Company and Contact

Filing Contact Information

Jamie Jensson,
1200 Jorie Blvd
Oak Brook, IL 60523

JenssonJ@mutualtrust.com
800-323-7320 [Phone] 5397 [Ext]

Filing Company Information

MTL Insurance Company
1200 Jorie Blvd.
Oak Brook, IL 60522
(800) 323-7320 ext. [Phone]

CoCode: 66427
Group Code:
Group Name:
FEIN Number: 36-1516780

State of Domicile: Illinois
Company Type: Life
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$300.00
Retaliatory?	No
Fee Explanation:	6 forms @ $50 each
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
MTL Insurance Company	$300.00	05/08/2012	59023984

SERFF Tracking Number:	*MTLC-128335519*	*State:*	*Arkansas*
Filing Company:	*MTL Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*6300-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2012 Applications*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/31/2012	05/31/2012
Approved-Closed	Linda Bird	05/10/2012	05/10/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Policy Reinstatement Application	Jamie Jensson	05/30/2012	05/30/2012
Form	Life Insurance Application	Jamie Jensson	05/30/2012	05/30/2012
Form	Policy Term Conversion/Purchase Option Application	Jamie Jensson	05/30/2012	05/30/2012
Form	Policy Reissue/Change Application	Jamie Jensson	05/30/2012	05/30/2012
Form	Policy Reissue/Change Supplemental Application	Jamie Jensson	05/30/2012	05/30/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request to re-open filing	Note To Filer	Linda Bird	05/29/2012	05/29/2012

SERFF Tracking Number:	*MTLC-128335519*	*State:*	*Arkansas*
Filing Company:	*MTL Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*6300-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2012 Applications*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 05/31/2012
Implementation Date:
Status: Approved-Closed
Comment: Corrections made to the original submission.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MTLC-128335519*	*State:*	*Arkansas*
Filing Company:	*MTL Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*6300-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2012 Applications*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form *(revised)*	Policy Reinstatement Application		Yes
Form	Policy Reinstatement Application	Replaced	Yes
Form *(revised)*	Life Insurance Application		Yes
Form	Life Insurance Application	Replaced	Yes
Form *(revised)*	Policy Term Conversion/Purchase Option Application		Yes
Form	Policy Term Conversion/Purchase Option Application	Replaced	Yes
Form *(revised)*	Policy Reissue/Change Application		Yes
Form	Policy Reissue/Change Application	Replaced	Yes
Form	Part II Application for Life Insurance		Yes
Form *(revised)*	Policy Reissue/Change Supplemental Application		Yes
Form	Policy Reissue/Change Supplemental Application	Replaced	Yes

SERFF Tracking Number:	*MTLC-128335519*	*State:*	*Arkansas*
Filing Company:	*MTL Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*6300-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2012 Applications*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 05/10/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MTLC-128335519*	*State:*	*Arkansas*
Filing Company:	*MTL Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*6300-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2012 Applications*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form *(revised)*	Policy Reinstatement Application		Yes
Form	Policy Reinstatement Application	Replaced	Yes
Form *(revised)*	Life Insurance Application		Yes
Form	Life Insurance Application	Replaced	Yes
Form *(revised)*	Policy Term Conversion/Purchase Option Application		Yes
Form	Policy Term Conversion/Purchase Option Application	Replaced	Yes
Form *(revised)*	Policy Reissue/Change Application		Yes
Form	Policy Reissue/Change Application	Replaced	Yes
Form	Part II Application for Life Insurance		Yes
Form *(revised)*	Policy Reissue/Change Supplemental Application		Yes
Form	Policy Reissue/Change Supplemental Application	Replaced	Yes

SERFF Tracking Number:	*MTLC-128335519*	*State:*	*Arkansas*
Filing Company:	*MTL Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*6300-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2012 Applications*		
Project Name/Number:	*/*		

Amendment Letter

Submitted Date: 05/30/2012

Comments:

The MIB requested we change the following things on the disclosure statement and signature page of our applications.

1. Refer to them as "MIB, Inc." instead of the "Medical Information Bureau"
2. Refer to them as "MIB" instead of "the Bureau"
3. Refer to them as a "not-for-profit" organization instead of "non-profit"

No other content has been changed from the first draft submitted.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
Form 2752-12	Application/Enrollment Form	Policy Reinstatement Application	Revised		MTLC-127313794	2752-11	53.200	2752-12 V.2.pdf
Form 6300-12	Application/Enrollment Form	Life Insurance Application	Revised		MTLC-127313794	6300-11	55.600	6300-12 V.2.pdf
Form 6328-12	Application/Enrollment Form	Policy Term Conversion/ Purchase Option Application	Revised		MTLC-127313794	6328-11	50.000	6328-12 V.2.pdf
Form 6329-12	Application/Enrollment Form	Policy Reissue/Change Application	Revised		MTLC-127313794	6329-11	51.100	6329-12 V.2.pdf
Form 6331-12	Application/Enrollment Form	Policy Reissue/Change Supplement	Revised		MTLC-127313794	6331-11	52.100	6331-12 V.2.pdf

SERFF Tracking Number:	*MTLC-128335519*	*State:*	*Arkansas*
Filing Company:	*MTL Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*6300-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2012 Applications*		
Project Name/Number:	*/*		

al
Application

SERFF Tracking Number:	*MTLC-128335519*	*State:*	*Arkansas*
Filing Company:	*MTL Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*6300-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2012 Applications*		
Project Name/Number:	*/*		

Note To Filer

Created By:

Linda Bird on 05/29/2012 08:02 AM

Last Edited By:

Linda Bird

Submitted On:

05/29/2012 08:02 AM

Subject:

Request to re-open filing

Comments:

Filing has been re-opened in order for correction to be made.

SERFF Tracking Number:	*MTLC-128335519*	*State:*	*Arkansas*
Filing Company:	*MTL Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*6300-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2012 Applications*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: 6300-12

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Form 2752-12	Application/ Enrollment Form	Policy Reinstatement Application	Revised	Replaced Form #: 2752-11 Previous Filing #: MTLC-127313794	53.200	2752-12 V.2.pdf
	Form 6300-12	Application/ Enrollment Form	Life Insurance Application	Revised	Replaced Form #: 6300-11 Previous Filing #: MTLC-127313794	55.600	6300-12 V.2.pdf
	Form 6328-12	Application/ Enrollment Form	Policy Term Conversion/Purchase Option Application	Revised	Replaced Form #: 6328-11 Previous Filing #: MTLC-127313794	50.000	6328-12 V.2.pdf
	Form 6329-12	Application/ Enrollment Form	Policy Reissue/Change Application	Revised	Replaced Form #: 6329-11 Previous Filing #: MTLC-127313794	51.100	6329-12 V.2.pdf
	Form 6330-12	Application/ Enrollment Form	Part II Application for Life Insurance	Revised	Replaced Form #: 6330-09 Previous Filing #: MTLC-126430356	55.800	6330-12 V.1.pdf
	Form 6331-12	Application/ Enrollment Form	Policy Reissue/Change Supplemental Application	Revised	Replaced Form #: 6331-11 Previous Filing #: MTLC-127313794	52.100	6331-12 V.2.pdf

Policy Reinstatement Application

MTL INSURANCE COMPANY®
A member of the MUTUAL TRUST FINANCIAL GROUP
1200 Jorie Boulevard • Oak Brook, Illinois 60523-2269
Toll Free: 1-800-323-7320 • www.mutualtrust.com

Application is hereby made to MTL Insurance Company for reinstatement of Policy Number: _____

1. Insured a. Name _____
   b. Date of Birth _____ c. Driver's License/Identification Number _____
   d. Street Address _____
   City _____ State _____ Zip Code _____ Phone _____

2. Insured Employment a. Occupation _____ b. Annual Earned Income $ _____
   c. Employer Name _____
   Street Address _____
   City _____ State _____ Zip Code _____

3. Has the Insured within the past 5 years:
   a. Applied for insurance or reinstatement without receiving it exactly as requested? ☐ Yes ☐ No
   b. Applied for or received any type of sickness or disability benefits, pension, or compensation? ☐ Yes ☐ No
   If Yes, provide details.

4. Has the Insured EVER been advised of, diagnosed, tested positive for, sought consultation for, or been treated for: cancer, stroke, or heart attack (heart disease) by a member of the medical profession? If Yes, provide details. ☐ Yes ☐ No

5. Is the Insured under any kind of treatment or on a restricted diet for any complaint or cause? If Yes, provide details. ☐ Yes ☐ No

6. Insured: Height _____ ft. _____ in. Weight _____ lbs Change in the past year: _____ lbs.
   Specify whether Gain or Loss and cause:

7. Has the Insured used tobacco or nicotine in any form in the past 12 months? ☐ Yes ☐ No

8. Has the Insured been treated, examined or advised by a member of the medical profession during the past 5 years? ☐ Yes ☐ No
   If Yes, provide details.

Diagnosis	Date of Diagnosis	Dates of Treatment	Name, Address, and Phone of Doctor

9. Has the Insured within the past five years flown in any type of aircraft as a pilot, student pilot or crew member, or does the Insured intend to do so in the next twelve months? If Yes, complete Aviation Supplement. ☐ Yes ☐ No

10. Has the Insured ever pled guilty to or been convicted of a felony? If Yes, provide details. ☐ Yes ☐ No

If this application is for reinstatement of a policy containing insurance protection on family members, Question 11 must be answered.

11. Have any family members, Spouse or Dependent Children, listed in the application for this policy been treated, examined or advised by a member of the medical profession during the past 5 years? If Yes, provide details. ☐ Yes ☐ No

12. If you had a premium paying rider at the time of lapse, would you like it reinstated? If Yes, please list riders to reinstate. ☐ Yes ☐ No

_____

_____

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1200 Jorie Boulevard • Oak Brook, Illinois 60523-2269
Toll Free: 1-800-323-7320 • www.mutualtrust.com

The undersigned hereby represent(s) that the foregoing statements and answers to the best of our (my) knowledge and belief, as well as any made in continuation hereof, are complete and true, and it is agreed as follows:

1. That all of said statements and answers, including those in continuation hereof, shall constitute the application and form the basis of any policy change that may be issued;
2. That the company shall incur no liability under this application until it has been received, approved, and any necessary premium has actually been paid to and accepted by the Company, all while the health, occupation and any other conditions relating to each person to be insured are as described in this application, in which case such policy change shall take effect as of the date shown therein;
3. That if the Company should issue a policy change different from that applied for, or in the case of apparent errors or omissions discovered by the Company, the Company is hereby authorized to amend this application by "Home Office Endorsement," and the acceptance of any policy change issued on this application shall constitute an approval of the policy provisions and a ratification of such amendment. However, written consent of the Insured and the Applicant, if other than the Insured, may be required for any amendment relating to amount, classification, plan of insurance or benefits.

I/We hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. or other organization, institution or person, that has any records or knowledge of me or my health, or of any of my minor children who are to be insured, to give to MTL Insurance Company, or its reinsurer(s), any such information. This authorization shall permit the above named company, or its reinsurer(s) or its representative, and any consumer reporting agency to verify my personal information and to view, copy, be furnished copies, or be given details of: (a) medical and other history; (b) mental or physical conditions; (c) evaluation, diagnosis, treatment, and prognosis of mental or physical conditions. Such information shall specifically include psychiatric treatment and drug or alcohol abuse treatment. I authorize MTL Insurance Company or its reinsurer(s) to make a brief report of my personal health information to MIB. I understand that the MIB may exchange my personal health information for remuneration when another MIB member inquires about me. A photocopy of this authorization shall be as valid as the original. This authorization may also be used to verify current address information and shall be in effect for this purpose only until revoked. Otherwise, this authorization expires two years after the date of the policy.

I/We acknowledge receipt of the disclosure statement regarding the investigative consumer report and MIB, Inc., and authorize MTL Insurance Company, or its reinsurer(s), to obtain a consumer investigative report if deemed necessary and to make a brief report regarding information relating to my health and insurability to the MIB.

☐ I elect to be interviewed if a consumer report is prepared in connection with this application. Please contact me between the hours of _____ and _____. Telephone number of Proposed Primary Insured _____ .

Who Must Sign: The Owner; the Insured, if other than the Owner; and any Irrevocable Beneficiary, Creditor Beneficiary, Assignee. Where the signature of a corporation is required, the name of the corporation should be filled in followed by the signature and title of an officer.

Signed at _____ Date _____
(City and State)

_____
Signature of Proposed Primary Insured (Age 15 and over)

_____
Signature of Owner (If other than Proposed Primary Insured)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Grantor (If other than Trustee)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Parent/Legal Guardian (Include Title/Relationship)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Irrevocable Beneficiary or Creditor Beneficiary

_____
Signature of Assignee

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date _____ Signature Witness (Agent) _____

Print Name _____

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Toll Free: 1-800-323-7320 • www.mutualtrust.com

This page must be given to the Primary Insured. A copy must also be given to each Additional Insured.

Disclosure Statement

Thank You for your request for a change to your policy. As part of the normal underwriting process, an investigative consumer report may be obtained. This report may include information as to your character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with you and/or friends, neighbors, and associates. Upon written request to our Policy Change Department, a summary of your rights and complete information as to the nature and scope of such report will be provided.

By use of the reports mentioned above, we are able to offer insurance coverage at the lowest possible cost to all who qualify. We appreciate the opportunity of serving your life insurance needs. We want to assure you that your application will receive the most prompt and favorable consideration possible.

Please Note that information regarding your insurability will be treated as confidential. However, MTL Insurance Company or its reinsurer(s) may make a brief report thereon to MIB, Inc. This is a not-for-profit membership organization of life insurance companies. It operates an information exchange on behalf of its members. Upon request by another member insurance company, to which you have applied for life or health insurance coverage or to which a claim is submitted, the MIB will supply that company with information it may have in its files.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact the MIB. You may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; telephone number 866-692-6901 (www.mib.com).

MTL Insurance Company or its reinsurer(s) may also release information in its file directly to other life insurance companies to which you may apply for life or health insurance or to which a claim for benefits may be submitted.

MTL Insurance Company **Oak Brook, Illinois 60523-2269**

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Application for Life Insurance

Instructions:

1. All questions must be answered. Any changes must be initialed by the Applicant. Lines drawn through questions and "N/A" are not acceptable; "**None**" must be used instead.

2. ***Owner's*** and ***Co-Owner's,*** if applicable, ***Taxpayer Identification Number*** must be provided on the Application (Questions 4c and 4i). If the Owner is other than the Insured, the Owner's signature is required. Each Owner must also complete and sign Page 11.

3. Medical Questions 21-30 **must** be completed for every Proposed Insured, even though a medical or paramedical examination is required. Failure to do so may result in an unnecessary delay. A separate Page 7 should be completed for each Proposed Insured.

Table of Contents

Signature(s) Required

How to speed your case through Underwriting

1. Complete all forms legibly and fully. Leaving blanks causes delays and often requires an amendment on delivery.

2. Schedule any necessary requirements, such as an exam, EKG, blood and urine tests promptly.

3. Give full names and addresses for any doctors named in this application, including phone numbers.

4. Track your applications through our Pending Application Summary Report available on our agent web site at https://agent.mutualtrust.com.

5. Fax completed applications to **800-522-0449**. If faxing the application, please do not mail the original application to the Home Office.

Conditional Receipt

Received from _____ a check in the amount of $ _____ paid with this insurance application to MTL Insurance Company. The Application bears the same date as this Receipt. I have advised each proposed insured and owner of the terms, conditions, and limitations of this Conditional Receipt. No agent is authorized to alter the terms of this Receipt, waive any terms, requirements or conditions, or pass on insurability.

Agent Signature _____ Date _____

TERMS, CONDITIONS AND LIMITS: The life insurance you applied for will not provide insurance coverage unless a contract is delivered to you. However, subject to the terms, conditions, and limitations of this Receipt, conditional insurance as provided by the terms and conditions of the policy/certificate applied for will become effective as of the Effective Date, which shall be the **latest** date of the following events:

- Signing of all parts of the Application, including any supplement, addenda, or amendment to the Application, and completion of any medical examination portion of the application;
- Date requested in the Application that is agreed to by the Insurer;
- The full initial premium for mode of payment chosen is received at our Home Office;
- Any additional information required by us, including attending physician statements/reports, is received at our Home Office.

This Receipt will provide no life insurance unless **each** of the following requirements are fulfilled during the lifetime of the person(s) proposed to be insured:

- As of the Effective Date, each person proposed to be insured is found to be insurable exactly as applied for in the Application pursuant to the Insurer's underwriting rules and standards, without any modification as to this insurance product, amount of insurance coverage, or premium rate;
- The payment taken with the Application is not less than the full initial premium for the mode of payment chosen and is honored immediately upon presentation;
- All medical information required by the Insurer is received at the Insurer's Home Office within 60 days of the completion of the Application.

If all requirements are not met, or the person(s) to be insured dies by suicide, the insurer's liability shall be limited to a full premium refund.

The aggregate amount of life insurance provided on the life of any person proposed to be insured which may become effective under this Receipt shall be the **lesser** of the amount applied for or $250,000.00.

All premium checks must be made payable to the MTL Insurance Company. DO NOT make any check payable to the agent or leave the payee blank. We do not accept third party checks, cashier checks, money orders or cash.

MTL Insurance Company **Oak Brook, Illinois 60523-2269**

Disclosure Statement

This section must be detached and given to the Primary Insured. A copy must also be given to each Additional Insured.

Thank You for your application for insurance. As part of the normal underwriting process, an investigative consumer report may be obtained. This report may include information as to your character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with you and/or friends, neighbors, and associates. Upon written request to our New Business Department, a summary of your rights and complete information as to the nature and scope of such report will be provided.

By use of the reports mentioned above, we are able to offer insurance coverage at the lowest possible cost to all who qualify. We appreciate the opportunity of serving your life insurance needs. We want to assure you that your application will receive the most prompt and favorable consideration possible.

Please Note that information regarding your insurability will be treated as confidential. However, MTL Insurance Company or its reinsurer(s) may make a brief report thereon to MIB, Inc. This is a not-for-profit membership organization of life insurance companies. It operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, the MIB will supply that company with information it may have in its files.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact the MIB. You may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; telephone number 866-692-6901 (www.mib.com).

MTL Insurance Company or its reinsurer(s) may also release information in its file directly to other life insurance companies to which you may apply for life or health insurance or to which a claim for benefits may be submitted.

MTL Insurance Company **Oak Brook, Illinois 60523-2269**

MTL Insurance Company

1200 Jorie Boulevard Oak Brook, Illinois 60523-2269

Part I Application for Life Insurance

1. Persons Proposed for Coverage (Please Print)

Full Legal Name (First, Middle Initial, Last)	Occupation	Social Security Number	Relationship to Primary Insured	State of Birth	Date of Birth mm/dd/yyyy	Age Nearest Birthday	Sex	Marital Status	Height Ft.	Height In.	Weight
a.			Primary Insured								
b.											
c.											
d.											
e.											

2. Primary Insured's Residence Address (Provide addresses for 5 years - current first, then most recent former, etc.)

Street Address or Rural Route (No PO Boxes)	City and State	Zip Code	Phone Number	Time There Yrs. Mos.
			Not Applicable	
			Not Applicable	

3. Primary Insured's Business Address (Present employer first, then most recent former employer)

a. Employer	Street Address	City and State	Zip Code	Phone Number	Time There Yrs. Mos.
				Not Applicable	

b. Gross Annual Earned Income $ _____

c. Total Gross Household Annual Earned Income $ _____

4. Ownership (Complete if other than Primary Insured)

Owner

a. Full Legal Name _____ Date of Birth _____

b. Relationship to Insured _____

c. Taxpayer Identification Number* _____ ☐ Individual (SSN) ☐ Corporation ☐ Partnership ☐ Trust

Grantor of Trust (If no Trust TIN) _____ Taxpayer Identification Number _____

d. Owner Street Address _____

City _____ State _____ Zip Code _____ Phone Number _____

e. Secondary Address (for notification of past due premiums and possible lapse in coverage)

Street Address _____

City _____ State _____ Zip Code _____ Phone Number _____

f. E-Mail Address _____

Co-Owner (if applicable)

g. Full Legal Name _____ Date of Birth _____

h. Relationship to Insured _____

i. Taxpayer Identification Number* _____ ☐ Individual (SSN) ☐ Corporation ☐ Partnership ☐ Trust

Grantor of Trust (If no Trust TIN) _____ Taxpayer Identification Number _____

j. Owner Street Address _____

City _____ State _____ Zip Code _____ Phone Number _____

k. Secondary Address (for notification of past due premiums and possible lapse in coverage)

Street Address _____

City _____ State _____ Zip Code _____ Phone Number _____

l. E-Mail Address _____

* If Ownership is a Trust, enter the Trust Taxpayer Identification Number. If no Trust TIN, enter Grantor's Taxpayer Identification Number.

5. Contingent Ownership Upon death, the rights of the deceased Owner shall pass to the Owner's estate, unless otherwise stated below.

a. Full Legal Name _____ Relationship to Insured _____ Date of Birth _____

b. Taxpayer Identification Number* _____ ☐ Individual (SSN) ☐ Corporation ☐ Partnership ☐ Trust

If Trust, Grantor Name _____ Taxpayer Identification Number _____

c. Owner Street Address _____

City _____ State _____ Zip Code _____ Phone Number _____

* If Ownership is a Trust, enter the Trust Taxpayer Identification Number. If not assigned, enter Grantor's Taxpayer Identification Number.

6. Plan of Insurance

Traditional Life

Plan _____

☐ Base Face Amount $ _____

☐ Money Purchase $ _____ Premium

☐ Automatic Premium Payment Provision (permanent plans only)

☐ Accelerated Death Benefit Rider

☐ Waiver of Premium - "Own Occupation" ☐ 2 year or ☐ 5 year

☐ Owner / Applicant Waiver of Premium - Primary Insured under Age 15. Include Owner / Applicant when answering all Questions.

☐ Single Premium Paid Up Insurance Rider

☐ Face Amount Or ☐ Premium $ _____

☐ Flexible Premium Paid Up Insurance Rider

Initial Premium $ _____

Maximum Annual Premium $ _____

Stipulated Annual Premium $ _____

Years Payable _____

☐ Disability Benefit Rider

Annual Benefit Amount $ _____

Benefit Period _____ (in years)

Flexible Premium Adjustable Life (Universal Life)

Plan _____

Initial Face Amount $ _____

Planned Annual Premium $ _____

☐ Waiver of Monthly Deduction Rider

Death Benefit Option (choose one)

☐ (A) Face Amount plus Account Value

☐ (B) Face Amount

☐ (C) Face Amount, plus Paid Premiums, minus Partial Withdrawals

No Lapse Period (choose one)

☐ 20 Year ☐ 30 Year ☐ 40 Year

Death Benefit Calculation Test (choose one)

☐ Guideline Premium

☐ Cash Value Accumulation

Additional Riders and Benefits - All Plans

☐ Accidental Death $ _____

☐ Children Insurance $ _____

☐ Purchase Option $ _____

☐ _____

☐ _____

☐ Term Insurance Rider

Proposed Insured's Name	Type	Amount

7. Dividend Options

Traditional Life

☐ Buy Paid Up Additions ☐ Accumulate at Interest ☐ Paid in Cash

☐ Apply Toward Premium ☐ Buy One Year Term Only

☐ Maximum Accumulation (Flexible Premium PUA Rider required)

☐ One Year Term (Equal to the cash value of the basic plan)

☐ One Year Term / PUA's (Modified Whole Life Plans only)

☐ _____

Flexible Premium Adjustable Life Plans

☐ Paid in Cash

☐ Apply Toward Account Value

8. Mode of premium payment desired

☐ Pre-Authorized Payment Plan ☐ Quarterly ☐ Semi-Annual ☐ Annual ☐ Other _____

9. Does any Proposed Insured have any existing individual life insurance or annuity contracts in force? ☐ Yes ☐ No

(If Yes, give details below)

	Name of Proposed Insured	Company Name	Policy Number	Amount	Year Issued	Accidental Death Amount	Annuity	Business Insurance
a.							☐	☐
b.							☐	☐
c.							☐	☐
d.							☐	☐
e.							☐	☐

10. Has any Proposed Insured, within the last ten years, been declined, postponed or refused reinstatement for life or health insurance or been offered a policy with an extra premium or otherwise not as applied for? ☐ Yes ☐ No
If Yes, state person, company, date and details.

11. Are any other applications for insurance on the life of any Proposed Insured now pending or contemplated? ☐ Yes ☐ No
If Yes, state amount, person, company, and details, including if all policies will be placed in force.

12. Is this policy applied for intended to replace existing life insurance or annuities on the life of any Proposed Insured? ☐ Yes ☐ No

a. If Yes, provide company, person, policy number, amount, type, and date of policies.

_____

b. If Yes, and replacement is also a 1035 Exchange: Estimated Amount $_____

13. Has any Proposed Insured within the past five years:

a. Engaged in any kind of Racing, Underwater Diving, Sky Diving, Parachuting, Ballooning, Hang Gliding, Climbing or Mountaineering, or does any Proposed Insured intend to do so in the next two years? If Yes, complete the Avocation Supplement. ☐ Yes ☐ No

b. Been convicted of driving while intoxicated or reckless driving or of two or more other moving violations, or had a driver's license suspended or revoked? If Yes, provide details and name of person. ☐ Yes ☐ No

_____

c. Provide the following information for any Proposed Insured. If Owner is other than Primary Insured, provide driver's license or identification number.

Name _____ Lic / ID No. _____ State _____ Exp Date _____

Name _____ Lic / ID No. _____ State _____ Exp Date _____

Name _____ Lic / ID No. _____ State _____ Exp Date _____

Name _____ Lic / ID No. _____ State _____ Exp Date _____

Name _____ Lic / ID No. _____ State _____ Exp Date _____

14. Are all Proposed Insureds citizens of the U.S.A.? If No, provide details, name of person, and the present status. ☐ Yes ☐ No

15. Has any Proposed Insured ever pled guilty to or been convicted of a felony? If Yes, provide details. ☐ Yes ☐ No

16. Has any Proposed Insured, within the past three years, flown in any type of aircraft as a pilot, student pilot or crew member, or does any Proposed Insured intend to do so in the next two years? If Yes, complete Aviation Supplement. ☐ Yes ☐ No

17. Does any Proposed Insured contemplate leaving the U.S.A. for travel or residence in the next two years? ☐ Yes ☐ No
If Yes, provide details.

18. Has any Proposed Insured or his/her company filed for bankruptcy within the past five years? If Yes, provide details and dates. ☐ Yes ☐ No

19. Beneficiary Designation

a. Death benefit proceeds are to be paid as follows, unless changed by written request at a later date. Complete address information if other than Primary Insured's address.

Beneficiary(ies) for Primary Insured

Primary Full Legal Name _____ Relationship to Insured _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Full Legal Name _____ Relationship to Insured _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Contingent Full Legal Name _____ Relationship to Insured _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Full Legal Name _____ Relationship to Insured _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Beneficiary(ies) for Insured _____

Primary Full Legal Name _____ Relationship to Insured _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Contingent Full Legal Name _____ Relationship to Insured _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Beneficiary(ies) for Insured _____

Primary Full Legal Name _____ Relationship to Insured _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Contingent Full Legal Name _____ Relationship to Insured _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Unless stated differently above:

- Any Additional Insured's death benefit shall be paid to the Primary Insured if living; if not living, to the estate of the Additional Insured.
- Any Children Insurance Rider death benefit shall be paid to the Primary Insured, if living; if not living, to the Primary Insured's legal Spouse as of the date of death of the Primary Insured, if living; if no spouse, or if not living, to the estate of such Child.
- Beneficiaries of the same class will share equally with the right of survivorship. If a Trustee is named above, payment to such Trustee will discharge the Company from further liability to the extent of that payment.

b. Child's Share to Trustee: Any payment which becomes due a child under the age of majority shall be paid, not to the child, but to the following as trustee for the child.

Full Legal Name of Trustee _____ Relationship to Insured _____

Street Address _____ City _____ State _____ Zip Code _____

20. Remarks

Home Office use only

Question Number	Name of Person	Details

 Proposed Insured: _____

Complete a separate page for each Proposed Insured or if applying for Owner/Applicant Waiver of Premium

Circle all applicable items and provide details for all "YES" answers in Question 28.

	Yes	No
21. Has the Proposed Insured EVER been advised of, diagnosed, tested positive for, sought consultation for, or been treated for: cancer, stroke or heart attack (heart disease) by a member of the medical profession?	☐	☐
22. Has the Proposed Insured, within the past 10 years, been advised of, diagnosed, tested positive for, sought consultation for, or been treated by a member of the medical profession, for:		
a. Convulsions, seizures, paralysis, mental or nervous disorder, attempted suicide, or recurrent dizziness, fainting or headaches?	☐	☐
b. Asthma, emphysema, tuberculosis, bronchitis or chronic respiratory disorder, sleep apnea or persistent shortness of breath?	☐	☐
c. Chest pain or tightness, palpitations, high blood pressure, heart murmur, other disorder of the heart or blood vessels?	☐	☐
d. Hepatitis, intestinal bleeding, ulcer, colitis, recurrent diarrhea or indigestion, or other disorder of the stomach, intestines, liver or pancreas?	☐	☐
e. Sugar, albumin, blood or pus in urine, venereal disease or other disorder of kidney, bladder, prostate, breasts or reproductive organs?	☐	☐
f. Diabetes, thyroid or other endocrine disorders?	☐	☐
g. Arthritis, or disorder of the muscles, bones, spine, back or joints?	☐	☐
h. Disorder of the skin, lymph glands, cyst or tumor?	☐	☐
i. Disorder of the eyes, anemia or other disorder of the blood?	☐	☐
23. Has the Proposed Insured, within the past 10 years, been medically diagnosed or treated by a physician as having AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or any other immunological disorder?	☐	☐
24. Has the Proposed Insured within the past 10 years:		
a. Used barbiturates, heroin, cocaine, marijuana, or any other illegal or controlled substance, except as prescribed by a physician?	☐	☐
b. Been advised to seek, or received counseling or treatment, or attended or joined any organization for alcohol or drug dependence?	☐	☐
25. Other than above, has the Proposed Insured within the past 5 years:		
a. Been diagnosed or treated for a mental or physical disorder, illness, injury or surgery?	☐	☐
b. Had a checkup or other consultation?	☐	☐
c. Been a patient in a hospital, clinic, medical center or other medical facility?	☐	☐
d. Had an EKG, stress test or any other diagnostic test (not including HIV tests)?	☐	☐
e. Been advised to have any diagnostic test (not including HIV tests), hospitalization or surgery which was not completed?	☐	☐
f. Requested or received a pension, benefits, or payment because of an injury, sickness or disability?	☐	☐
26. Has the Proposed Insured:		
a. Lost or gained more than 15 lbs in the past year? If Yes, indicate reason and amount of gain or loss.	☐	☐
b. Used tobacco or nicotine in any form in the past 12 months?	☐	☐
c. Used tobacco or nicotine in any form in the past 48 months?	☐	☐
27. Is the Proposed Insured currently under observation by a physician or taking any prescription medication(s)?	☐	☐

28. Details of "YES" answers. ***Identify question number and include***: Diagnoses, prescription medication(s), dates, duration, and name and addresses of all attending physicians and medical facilities. If additional space is needed, use Question 20.

Question	Details

29. Primary Care Physician: Name: _____ Phone Number: _____

Address: _____

30. Proposed Insured Family History:

	Yes	No
a. Has any family member been diagnosed with diabetes, cancer, stroke, heart or kidney disease or mental illness? (If Yes, give details including date of diagnosis)	☐	☐

b.

	Age if Living	Cause of Death	Age at Death		Number Living	Number Deceased	Cause of Death	Age at Death
Father				Brothers				
Mother				Sisters				

The applicant has made a payment of $_____, for which a Conditional Receipt, bearing the same date as this application, has been issued, and the terms and conditions of said Conditional Receipt are hereby accepted. (Do not insert amount unless payment is actually made.)

The undersigned hereby represent(s) that the foregoing statements and answers to the best of our (my) knowledge and belief, as well as any made in continuation hereof, are complete and true, and it is agreed as follows:

1. That all of said statements and answers, including those in continuation hereof, shall constitute the application and form the basis of any policy that may be issued;
2. That the company shall incur no liability under this application until it has been received, approved, a policy issued and delivered and the full first premium has actually been paid to and accepted by the Company, all while the health, occupation and any other conditions relating to each person to be insured are as described in this application, in which case such policy shall take effect as of the date of issue shown therein; **Provided**, however, that if payment is made in exchange for a Conditional Receipt bearing the same date as Part I of this application, insurance shall take effect if the conditions stated in said receipt are satisfied;
3. That if the Company should issue a policy different from that applied for, or in the case of apparent errors or omissions discovered by the Company, the Company is hereby authorized to amend this application by "Home Office Endorsement", and the acceptance of any policy issued on this application shall constitute an approval of the policy provisions and a ratification of such amendment. However, written consent of the Insured and the Applicant, if other than the Insured, may be required for any amendment relating to amount, classification, plan of insurance or benefits.

I/We hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. or other organization, institution or person, that has any records or knowledge of me or my health, or of any of my minor children who are to be insured, to give to MTL Insurance Company, or its reinsurer(s), any such information. This authorization shall permit the above named company, or its reinsurer(s) or its representative, and any consumer reporting agency to verify my personal information and to view, copy, be furnished copies, or be given details of: (a) medical and other history; (b) mental or physical conditions; (c) evaluation, diagnosis, treatment, and prognosis of mental or physical conditions. Such information shall specifically include psychiatric treatment and drug or alcohol abuse treatment. I authorize MTL Insurance Company or its reinsurer(s) to make a brief report of my personal health information to MIB. I understand that the MIB may exchange my personal health information for remuneration when another MIB member inquires about me. A photocopy of this authorization shall be as valid as the original. This authorization may also be used to verify current address information and shall be in effect for this purpose only until revoked. Otherwise, this authorization expires two years after the date of the policy.

I/We acknowledge receipt of the disclosure statement regarding the investigative consumer report and MIB, Inc., and authorize MTL Insurance Company, or its reinsurer(s), to obtain a consumer investigative report if deemed necessary and to make a brief report regarding information relating to my health and insurability to the MIB.

☐ I elect to be interviewed if a consumer report is prepared in connection with this application. Please contact me between the hours of _____ and _____. Telephone number of Proposed Primary Insured _____

Who Must Sign: The Owner; the Insured, if other than the Owner; and any Irrevocable Beneficiary. Where the signature of a corporation is required, the name of the corporation should be filled in followed by the signature and title of an officer.

Signed at _____ Date _____ _____
(City and State) Signature of Proposed Primary Insured (Age 15 and over)

_____ _____
Signature of Owner (If other than Proposed Primary Insured) Signature of Other Proposed Insured (Age 15 and over)

_____ _____
Signature of Grantor (If other than Trustee) Signature of Other Proposed Insured (Age 15 and over)

_____ _____
Signature of Irrevocable Beneficiary Signature of Other Proposed Insured (Age 15 and over)

_____ _____
Signature of Parent/Legal Guardian (Include Title/Relationship) Signature of Witness (Agent)

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AGENT'S CERTIFICATION: To the best of my knowledge, a replacement of life insurance or annuities ☐ is ☐ is not involved in this transaction. I also certify that prior to signing this application, I delivered to the Applicant any proposal, outline of coverage, Buyer's Guide, comparison and/or disclosure statement required by Federal Law or by the law in the state where this application was signed.

Date _____ Signature of Agent _____

Print Name _____

Writing Agent Must Complete This Form

Agent's Report

MTL Insurance Company

1. What is the purpose of this insurance? ☐ Executive Bonus ☐ Key Person ☐ Buy / Sell ☐ Deferral ☐ Creditor ☐ Estate Liquidity ☐ Personal ☐ Other _____

2. Personal Finances:
   a. Total Assets: $ _____ b. Total Liabilities: $ _____ c. Net Worth: $ _____
   d. Unearned Income: $ _____ e. Tax Status: _____
   f. Owner's Financial Objectives: _____
   g. Other information affecting Owner's decision to purchase this policy: _____

   If face amount applied for <u>exceeds</u> one million dollars, submit a current Personal Financial Questionnaire Form 4510.

3. Business Finances ***(Complete only if this is Business Insurance)***:
   a. Total Assets: $ _____ b. Total Liabilities: $ _____ c. Net Worth: $ _____
   d. Net Profit after Taxes for Past Two Years: Last Year $ _____ Previous Year $ _____
   e. What is the Proposed Insured's percentage of ownership in this firm? _____
   f. Is there business insurance applied for or in force on other key members of this firm? If Yes or No, provide details. ☐ Yes ☐ No

   _____

   g. Type of Business ☐ Sole Owner ☐ Partnership ☐ Corporation ☐ Other _____

   If face amount applied for <u>exceeds</u> one million dollars - Submit Business Financial Questionnaire Form 4513 along with the required business financial statements.

4. How long and how well have you known the Proposed Insured? (If related, provide details) _____

5. Are you aware of anything about the health, habits, or avocations, which may affect the insurability of any person proposed for insurance? If Yes, provide full details in Question 13. ☐ Yes ☐ No

6. If Insured is married: (a) Spouse's name _____ (b) How much insurance on spouse? _____
   (c) If no insurance, explain. _____

7. If Insured is under age 15: Indicate amount of insurance on each parent and each sibling in Question 13.

8. Additional <u>Or</u> Alternate policy requests (maximum of two) - Policy to be same as original, except for the following:

To be Placed as follows:	a. ☐ Addition to Original ☐ Instead of Original	b. ☐ Addition to Original ☐ Instead of Original
HO Use Only a. _____ b. _____	Amount $ _____ Plan: _____ Benefits: _____ Other: _____	Amount $ _____ Plan: _____ Benefits: _____ Other: _____

9. Agent Information:
   a. Writing Agent: Name _____ Code _____ _____ %
   b. If case is to be shared with other licensed and contracted agent(s), complete the following: +

   % must be whole number and at least 10%

   Name _____ Code _____ _____ %
   Name _____ Code _____ _____ %
   Name _____ Code _____ _____ %
   100 %

10. Agent's phone number: _____

11. Was a sales concept used in this sale? If Yes, indicate below. ☐ Yes ☐ No
    ☐ IBC ☐ Circle of Wealth ☐ LEAP ☐ Other _____

12. Issue Instructions: ☐ Call for Instructions ☐ Companion File(s) _____

13. Remarks and special requests:

CERTIFICATE: I was ☐ or was not ☐ personally in the presence of the Insured(s) when this application was completed and signed. Answers to all questions are properly recorded and, to the best of my knowledge, are complete and true. I represent that I have only used company-approved material and copies of all sales material were left with the applicant. I gave the Proposed Insured(s) the consumer notice regarding the MIB and Fair Credit Reporting Act. I have reasonable grounds for believing that the recommendation is suitable on the basis of facts disclosed. I recommend acceptance at standard rates and without restriction, except as stated above.

Date _____ Writing Agent Signature _____

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Authorization for Release of Medical Information for the purpose of applying for life insurance

This authorization complies with the HIPAA Privacy Rules

Name of Proposed Insured/Patient:

_____

(Last) (First) (Middle) (Maiden) (Date of Birth)

I/We authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record, including my prescription drug history, and any other protected health information concerning me to MTL Insurance Company ("the Company") and its agents, employees, and representatives including retrieval service companies. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By signing below, I/we acknowledge that any agreements I/we have made to restrict our protected health information do not apply to this authorization and we instruct any physician, health care professional, hospital, clinic, laboratory, pharmacy, Pharmacy Benefit Manager, medical facility, or other health care provider to release and disclose our entire medical record without restriction.

I/We understand this authorization is voluntary and that such information will be used by the Company for the purpose of evaluating my application for life insurance. Further, I understand that my authorization is required for the Company to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and no longer protected by the federal privacy laws or required by law.

I/We understand this consent may be revoked in writing at anytime. This consent may not be revoked to the extent that disclosure of information has already occurred, prior to the receipt of revocation by the Proposed Insured(s). Authorization will be considered valid for a period of time not to exceed 24 months from the date that this authorization was signed. A photocopy of this authorization is to be considered as valid as the original. A copy of this authorization will be provided by the Company upon request.

IMPORTANT: This authorization must be signed and dated by all Applicants as required. (This includes your spouse and all dependents age 15 or over who are applying for coverage.) Missing signatures or dates may cause a delay in processing.

_____ _____
Signature of Proposed Primary Insured (Age 15 and over) Mo. Day Yr.

_____ _____
Signature of Spouse (Only if to be Insured) Mo. Day Yr.

_____ _____
Signature of Parent / Legal Guardian (If minor under age 15) Mo. Day Yr.
(Include Title and Relationship)

_____ _____
Signature of Other Proposed Insured (Age 15 or over) Mo. Day Yr.

_____ _____
Signature of Other Proposed Insured (Age 15 and over) Mo. Day Yr.

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Request for Owner Taxpayer Identification Number and Certification

Taxpayer Information

Full Legal Name _____ Date of Birth (if individual) _____

Business Name / Disregarded Entity Name* (if different from above) _____

☐ Individual/Sole Proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited Liability Company. Enter the tax classification (C = C corporation, S = S corporation, P = partnership) ____ ☐ Exempt payee

☐ Other _____

Taxpayer Identification Number (TIN)

The TIN provided must match the name given on the "Full Legal Name" line to avoid backup withholding.

Select and enter your TIN*

- Individuals - this is your social security number
- Sole Proprietor - this is your social security number. (The IRS will also accept your employer identification number.)
- Disregarded Entity - this is your social security number.
- Other entities - this is your employer identification number.

☐ Social Security Number **or** ☐ Employer Identification Number TIN _____

Certification

Under penalties of perjury, I certify that;

1. The number shown on this form is my correct taxpayer identification number; and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends; or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am an individual who is U. S. citizen or U.S. resident alien; a partnership, corporation, company, or association created or organized in the United States or under the laws of the United States; an estate (other than a foreign estate); or a domestic trust (as defined in Regulations section 301.7701-7).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you **are** currently subject to backup withholding because you have failed to report all interest or dividends on your tax return.*

_____ _____
Date Signed Signature of Policyowner

_____
Title (if Corporation / Partnership / Trustee)

* Please refer to Form W-9 Instructions at www.irs.gov

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Authorization for Disclosure of Information for Underwriting Purposes

I, the undersigned, authorize MTL Insurance Company (MTL) to disclose certain personal and confidential information to my MTL agent and his or her agency for the purpose of reviewing this information and explaining MTL's underwriting procedures and decisions or other insurance related actions concerning my application. I understand that the information covered by this Authorization includes personal information, including, but not limited to, health information about me collected by MTL in the course of its underwriting practices.

I understand that MTL's employees, agents, and representatives are required to adhere to the HIPAA policies and are to receive and use personal information for the express purposes of processing my insurance application along with any other necessary and related insurance practices.

I also understand that I may revoke this Authorization at any time by sending MTL written notification of my revocation, except to the extent of any action taken or information received in reliance on this Authorization prior to MTL's receipt of the revocation. If this Authorization is for someone other than myself, that individual and my authority to act on his/her behalf are explained below. Any information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected.

This Authorization is valid for a period of twenty-four (24) months from the date of my signature below. A copy of this Authorization may be used in place of the original.

_____

Name of Individual Whose Information is Covered by this Authorization *(Please Print)*

_____ _____

Signature of Individual or Representative Date

_____

Name of Representative with Authority to Act on Behalf of the Individual Whose Information is Covered by this Authorization, if applicable *(Please Print)*

_____

Relationship of Representative to Individual *(If Applicable and Proof Required)*

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Pre-Authorized Payment Plan Request

☐ **New Plan** ☐ **Add to Existing Plan** ☐ **Change of Bank**

I want to make premium payments through the **Pre-Authorized Payment Plan**. I instruct MTL Insurance Company to make monthly withdrawals from the account I have specified and pay premiums on the policy(ies) listed. Make the deduction on the _____ of each month, beginning _____ (month/year).

Please Note: The day specified must be the 1st through the 28th **only** - if you choose the 29th, 30th, or 31st, the deduction will occur on the 28th. If a day is not specified, the deduction will be on the same day of the month as the Policy Issue Date.

Policy Number(s)

_____ _____ _____ _____

_____ _____ _____ _____

☐ Automatic Loan Repayment (ALR): Draw an additional $ _____ (minimum $25.00) each month and apply it to reduce the loan on Policy Number _____ . If this monthly payment exceeds the amount needed to repay the loan completely, the deduction will be adjusted to the payoff amount and this part of the agreement will end.

I understand and agree that:

1. The Plan will be effective when approved by the Company.
2. The Company will send no premium notices for policies on the Plan.
3. This Plan may be stopped by the Owner, the Depositor if other than the Owner, or by the Company at any time upon written notification.
4. If the Plan is terminated for any reason, premiums will be payable as provided in the policy.

_____ _____
Date Signed Depositor(s)

_____ _____
Owner (other than Depositor)

Affix Specimen Check to the Back Side of this form.

Bank Name _____

Address _____

Account Number _____ Type ☐ Checking ☐ Savings

Policy Term Conversion / Purchase Option Application

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Side A

☐ **Conversion:** This is an application to convert the Term Coverage on Policy Number _____ on the life of _____ to a new policy as stated below.

Remove any remaining Term Coverage from the original policy? ☐ Yes ☐ No

☐ **Purchase Option:** This is an application to request additional insurance on the life of _____, to be issued in accordance to the provisions of Policy Number _____, and as stated below.

Insurance Desired: $_____ face amount on the _____ plan to be dated _____, at the attained age of the Insured.

The policy provisions relating to incontestability and suicide contained in any additional or new policy shall extend from the Date of Issue of the original policy and not from the Date of Issue of such additional or new policy.

Additional Riders and Benefits:

☐ Single Premium Paid Up Insurance Rider:
☐ Face Amount or ☐ Premium $ _____

☐ Flexible Premium Paid Up Insurance Rider:
Initial Premium $ _____
Maximum Annual Premium $ _____
Stipulated Annual Premium $ _____
Years Payable _____

☐ Disability Benefit Rider: Benefit Period _____(in yrs)
Annual Benefit Amount $ _____

☐ Children Insurance $ _____

☐ Term Insurance Rider:

Proposed Insured's Name	Type	Amount

☐ Waiver of Premium - "Own Occupation" ☐ 2 yr or ☐ 5 yr
☐ Accelerated Death Benefit Rider
☐ Accidental Death Benefit $ _____
☐ _____
☐ Automatic Premium Payment Provision

Additions, that are not guaranteed per the policy provisions, are subject to evidence of insurability satisfactory to the Company. Complete Sides A, B, and the HIPAA Form. If requesting a new Proposed Insured - Complete Pages 1 and 2 of Form 6331-12.

Dividend Options
☐ Buy Paid Up Additions ☐ Apply Toward Premium ☐ Maximum Accumulation (Flexible PUA Rider required)
☐ Accumulate at Interest ☐ Buy One Year Term Only ☐ One Year Term (Equal to the cash value of the basic plan)
☐ Paid in Cash ☐ _____ ☐ One Year Term / PUA's (Modified Whole Life Plans only)

Mode of Premium Payment desired
☐ Annual ☐ Quarterly ☐ Semi-Annual
☐ Pre-Authorized Payment Plan ☐ Other: _____

Ownership: The Owner of any policy issued hereon shall be the Insured, unless otherwise stated below:

Full legal name _____ Relationship to Insured _____ Date of Birth _____
Taxpayer Identification Number* _____ ☐ Individual (SSN) ☐ Corporation ☐ Partnership ☐ Trust
Grantor of Trust (If no Trust TIN) _____ Taxpayer Identification Number _____
Street Address _____ City _____
State _____ Zip Code _____ Phone Number _____ Email _____

Contingent Owner - Upon death, the rights of the deceased Owner shall pass to the estate of the Owner, unless otherwise stated below:

Full legal name _____ Relationship to Insured: _____ Date of Birth _____
Taxpayer Identification Number* _____ ☐ Individual (SSN) ☐ Corporation ☐ Partnership ☐ Trust
Grantor of Trust (If no Trust TIN) _____ Taxpayer Identification Number _____

* If Ownership is a Trust, enter the Trust Taxpayer Identification Number. If no Trust TIN, enter Grantor's Taxpayer Identification Number.

Beneficiary Designation: Death benefit proceeds are to be paid as follows, unless changed by written request at a later date. Unless, otherwise stated, beneficiaries of the same class will share equally, with right of survivorship.

Primary
Full Legal Name _____ Relationship to Insured _____ Date of Birth _____
Street Address _____ City _____ State _____ Zip Code _____
Full Legal Name _____ Relationship to Insured _____ Date of Birth _____
Street Address _____ City _____ State _____ Zip Code _____

Contingent
Full Legal Name _____ Relationship to Insured _____ Date of Birth _____
Street Address _____ City _____ State _____ Zip Code _____
Full Legal Name _____ Relationship to Insured _____ Date of Birth _____
Street Address _____ City _____ State _____ Zip Code _____

Policy Term Conversion / Purchase Option Application

MTL Insurance Company

Side B

I hereby declare that the following statements and answers are complete and true to the best of my knowledge and belief, whether written in my own hand or not. I agree that they shall be a basis for the policy applied for under the terms of Policy Number: _____

1. Insured or Applicant
   a. Full Legal Name _____
   b. Date of Birth _____ c. Driver's License / Identification Number _____
   d. Street Address _____
   City: _____ State: _____ Zip Code: _____ Phone _____

2. Insured or Applicant Employment
   a. Occupation _____ b. Annual Earned Income $ _____
   c. Employer Name _____
   Street Address _____
   City _____ State _____ Zip Code _____

3. a. Total Insurance now in force with other companies:
   Life $_____ Accidental Death $_____ Monthly Disability Income $_____
   b. Last Policy Issued _____ (Date) by _____ (Company)

4. Has the Insured within the past five years flown in any type of aircraft as a pilot, student pilot or crew member, or does the Insured intend to do so in the next twelve months? If Yes, complete Aviation Supplement. ☐ Yes ☐ No

5. Has the Insured EVER been advised of, diagnosed, tested positive for, sought consultation for, or been treated for: cancer, stroke, or heart attack (heart disease) by a member of the medical profession? If Yes, provide details. ☐ Yes ☐ No

6. Height_____ ft._____ in. Weight _____ lbs Change in the past year _____ lbs.
   Specify whether Gain or Loss and cause: _____

7. Has the Insured used tobacco or nicotine in any form in the past 12 months? ☐ Yes ☐ No

8. Has the Insured within the past 5 years:
   a. Applied for insurance or reinstatement without receiving it exactly as requested? ☐ Yes ☐ No
   b. Applied for or received any type of sickness or disability benefits, pension, or compensation? ☐ Yes ☐ No
   If Yes, provide details _____

9. Enter name and address of personal doctor (usual medical advisor), also date and reason last consulted.
   Name _____ Street Address _____
   City _____ State _____ Zip Code _____ Phone _____
   Date _____ Reason _____

10. Has the Insured ever pled guilty to or been convicted of a felony? If Yes, provide details. ☐ Yes ☐ No

11. Has the Insured been treated, examined or advised by a member of the medical profession during the past 5 years? If Yes, provide details below. ☐ Yes ☐ No
    Reference to previous examinations for this Company is not acceptable as an answer in the following section.

Diagnosis	Date of Diagnosis	Date of Treatment	Name, Address, and Phone of Doctor

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The undersigned hereby represent(s) that the foregoing statements and answers to the best of our (my) knowledge and belief, as well as any made in continuation hereof, are complete and true, and it is agreed as follows:

1. That all of said statements and answers, including those in continuation hereof, shall constitute the application and form the basis of any policy change that may be issued;
2. That the company shall incur no liability under this application until it has been received, approved, and any necessary premium has actually been paid to and accepted by the Company, all while the health, occupation and any other conditions relating to each person to be insured are as described in this application, in which case such policy change shall take effect as of the date shown therein;
3. That if the Company should issue a policy change different from that applied for, or in the case of apparent errors or omissions discovered by the Company, the Company is hereby authorized to amend this application by "Home Office Endorsement," and the acceptance of any policy change issued on this application shall constitute an approval of the policy provisions and a ratification of such amendment. However, written consent of the Insured and the Applicant, if other than the Insured, may be required for any amendment relating to amount, classification, plan of insurance or benefits.

I/We hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. or other organization, institution or person, that has any records or knowledge of me or my health, or of any of my minor children who are to be insured, to give to MTL Insurance Company, or its reinsurer(s), any such information. This authorization shall permit the above named company, or its reinsurer(s) or its representative, and any consumer reporting agency to verify my personal information and to view, copy, be furnished copies, or be given details of: (a) medical and other history; (b) mental or physical conditions; (c) evaluation, diagnosis, treatment, and prognosis of mental or physical conditions. Such information shall specifically include psychiatric treatment and drug or alcohol abuse treatment. I authorize MTL Insurance Company or its reinsurer(s) to make a brief report of my personal health information to MIB. I understand that the MIB may exchange my personal health information for remuneration when another MIB member inquires about me. A photocopy of this authorization shall be as valid as the original. This authorization may also be used to verify current address information and shall be in effect for this purpose only until revoked. Otherwise, this authorization expires two years after the date of the policy.

I/We acknowledge receipt of the disclosure statement regarding the investigative consumer report and MIB, Inc., and authorize MTL Insurance Company, or its reinsurer(s), to obtain a consumer investigative report if deemed necessary and to make a brief report regarding information relating to my health and insurability to the MIB.

☐ I elect to be interviewed if a consumer report is prepared in connection with this application. Please contact me between the hours of _____ and _____. Telephone number of Proposed Primary Insured _____ .

Who Must Sign: The Owner; the Insured, if other than the Owner; and any Irrevocable Beneficiary, Creditor Beneficiary, Assignee. Where the signature of a corporation is required, the name of the corporation should be filled in followed by the signature and title of an officer.

Signed at _____ Date _____
(City and State)

_____
Signature of Proposed Primary Insured (Age 15 and over)

_____
Signature of Owner (If other than Proposed Primary Insured)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Grantor (If other than Trustee)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Parent/Legal Guardian (Include Title/Relationship)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Irrevocable Beneficiary or Creditor Beneficiary

_____
Signature of Assignee

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing and false, incomplete, or misleading information is guilty of a felony of the third degree..

Date _____ Signature Witness (Agent) _____

Florida License Identification Number _____ Print Name _____

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This page must be given to the Primary Insured. A copy must also be given to each Additional Insured.

Disclosure Statement

Thank You for your request for a change to your policy. As part of the normal underwriting process, an investigative consumer report may be obtained. This report may include information as to your character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with you and/or friends, neighbors, and associates. Upon written request to our Policy Change Department, a summary of your rights and complete information as to the nature and scope of such report will be provided.

By use of the reports mentioned above, we are able to offer insurance coverage at the lowest possible cost to all who qualify. We appreciate the opportunity of serving your life insurance needs. We want to assure you that your application will receive the most prompt and favorable consideration possible.

Please Note that information regarding your insurability will be treated as confidential. However, MTL Insurance Company or its reinsurer(s) may make a brief report thereon to MIB, Inc. This is a not-for-profit membership organization of life insurance companies. It operates an information exchange on behalf of its members. Upon request by another member insurance company, to which you have applied for life or health insurance coverage or to which a claim is submitted, the MIB will supply that company with information it may have in its files.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact the MIB. You may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; telephone number 866-692-6901 (www.mib.com).

MTL Insurance Company or its reinsurer(s) may also release information in its file directly to other life insurance companies to which you may apply for life or health insurance or to which a claim for benefits may be submitted.

MTL Insurance Company **Oak Brook, Illinois 60523-2269**

Policy Reissue / Change Application

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Side A

This is an application to change Policy Number _____ on the life of _____ as stated below, and the policy is returned to the Company for the change.

☐ **REISSUE** *(Changes made at inception).* Allowed up to six months from the date of issue, with the return of Page 3.

☐ **CHANGE** *(Changes made after inception).* Over six months from the date of issue. Original policy will be endorsed.

Base Plan of Insurance

A change to a lower premium plan may be subject to evidence of insurability satisfactory to the Company. Complete Sides A, B, and the HIPAA Form.

Current: _____ Face Amount: _____

Proposed: _____ Face Amount: _____

☐ **Redate to** _____ *Subject to evidence of insurability if occurring more than 30 days after date of issue. Complete Sides A, B, and the HIPAA Form.*

☐ **Modification of Risk Classification** _____ *Subject to evidence of insurability satisfactory to the Company. Complete Sides A, B, and the HIPAA form.*

Riders and Benefits

Additions are subject to evidence of insurability satisfactory to the Company. Complete Sides A, B, and the HIPAA Form. If requesting a new Proposed Insured - Complete Pages 1 and 2 of Form 6331-12.

Full Pay	Add	Change	Remove	
				Traditional Life
	☐	☐	☐	Single Premium Paid Up Insurance Rider ☐ Face Amount or ☐ Premium $ _____
☐	☐	☐	☐	Annual Premium Paid Up Insurance Rider ☐ Face Amount or ☐ Premium $ _____
				☐ Convert to Flexible Premium Paid Up Insurance Rider. (Indicate any changes to the Stipulated or Maximum annual premium amounts in the Flexible Premium Paid Up Insurance Rider section.)
				☐ Convert the existing Waiver of Premium benefit to the Disability Benefit Rider. (Complete the Disability Benefit Rider information in the Flexible Premium Paid Up Insurance Rider section)
	☐	☐	☐	Flexible Premium Paid Up Insurance Rider
				Initial Premium $ _____ Maximum Annual Premium $ _____
				Stipulated Annual Premium $ _____ Years Payable _____
				☐ Disability Benefit Rider: Annual Benefit Amount $ _____ Benefit Period _____ (in yrs)
	☐		☐	Accelerated Death Benefit Rider
	☐	☐	☐	Waiver of Premium - "Own Occupation" ☐ 2 year or ☐ 5 year
				Universal Life
	☐		☐	Waiver of Monthly Deduction Rider
				Additional Riders and Benefits
	☐	☐	☐	Accidental Death $ _____
	☐	☐	☐	Children Insurance $ _____
	☐	☐	☐	Purchase Option $ _____

	Proposed Insured's Name	Type	Amount
☐ ☐ ☐	Term Insurance Rider		
☐ ☐ ☐	Term Insurance Rider		
☐ ☐ ☐			

Prevent MEC ☐ Yes ☐ No

Surrender Paid Up Additions Rider ☐ Single ☐ Annual ☐ Flexible | ☐ Full or ☐ Partial | ☐ Face Amount or ☐ Cash Value

Amount $ _____ Federal Taxes to be Withheld $ _____

Disbursement Instructions _____

Dividend Options

☐ Buy Paid Up Additions ☐ Apply Toward Premium ☐ Maximum Accumulation (Flexible PUA Rider required)

☐ Accumulate at Interest ☐ Buy One Year Term Only ☐ One Year Term (Equal to the cash value of the basic plan)

☐ Paid in Cash ☐ _____ ☐ One Year Term/PUA's (Modified Whole Life Plans only)

Mode of Premium Payment desired ☐ Annual ☐ Quarterly ☐ Semi-Annual ☐ Pre-Authorized Payment Plan ☐ Other _____

Policy Reissue / Change Application

MTL Insurance Company

Side B

I hereby declare that the following statements and answers are complete and true to the best of my knowledge and belief, whether written in my own hand or not. I agree that they shall be a basis for the policy reissue / change applied for under the terms of Policy Number: _____

1. Insured or Applicant
   a. Full Legal Name _____
   b. Date of Birth _____ c. Driver's License / Identification Number _____
   d. Street Address _____
   City: _____ State: _____ Zip Code: _____ Phone _____

2. Insured or Applicant Employment
   a. Occupation _____ b. Annual Earned Income $ _____
   c. Employer Name _____
   Street Address _____
   City _____ State _____ Zip Code _____

3. a. Total Insurance now in force with other companies:
   Life $_____ Accidental Death $_____ Monthly Disability Income $_____
   b. Last Policy Issued _____ by _____
   Date Company

4. Has the Insured within the past five years flown in any type of aircraft as a pilot, student pilot or crew member, or does the Insured intend to do so in the next twelve months? If Yes, complete Aviation Supplement. ☐ Yes ☐ No

5. Has the Insured EVER been advised of, diagnosed, tested positive for, sought consultation for, or been treated for: cancer, stroke, or heart attack (heart disease) by a member of the medical profession? If Yes, provide details. ☐ Yes ☐ No

6. Height_____ ft._____ in. Weight _____ lbs Change in the past year _____ lbs.
   Specify whether Gain or Loss and cause: _____

7. Has the Insured used tobacco or nicotine in any form in the past 12 months? ☐ Yes ☐ No

8. Has the Insured within the past 5 years:
   a. Applied for insurance or reinstatement without receiving it exactly as requested? ☐ Yes ☐ No
   b. Applied for or received any type of sickness or disability benefits, pension, or compensation? ☐ Yes ☐ No
   If Yes, provide details _____

9. Enter name and address of personal doctor (usual medical advisor), also date and reason last consulted.
   Name _____ Street Address _____
   City _____ State _____ Zip Code _____ Phone _____
   Date _____ Reason _____

10. Has the Insured ever pled guilty to or been convicted of a felony? If Yes, provide details. ☐ Yes ☐ No

11. Has the Insured been treated, examined or advised by a member of the medical profession during the past 5 years? If Yes, provide details below. ☐ Yes ☐ No
    Reference to previous examinations for this Company is not acceptable as an answer in the following section.

Diagnosis	Date of Diagnosis	Date of Treatment	Name, Address, and Phone of Doctor

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The undersigned hereby represent(s) that the foregoing statements and answers to the best of our (my) knowledge and belief, as well as any made in continuation hereof, are complete and true, and it is agreed as follows:

1. That all of said statements and answers, including those in continuation hereof, shall constitute the application and form the basis of any policy change that may be issued;
2. That the company shall incur no liability under this application until it has been received, approved, and any necessary premium has actually been paid to and accepted by the Company, all while the health, occupation and any other conditions relating to each person to be insured are as described in this application, in which case such policy change shall take effect as of the date shown therein;
3. That if the Company should issue a policy change different from that applied for, or in the case of apparent errors or omissions discovered by the Company, the Company is hereby authorized to amend this application by "Home Office Endorsement," and the acceptance of any policy change issued on this application shall constitute an approval of the policy provisions and a ratification of such amendment. However, written consent of the Insured and the Applicant, if other than the Insured, may be required for any amendment relating to amount, classification, plan of insurance or benefits.

I/We hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. or other organization, institution or person, that has any records or knowledge of me or my health, or of any of my minor children who are to be insured, to give to MTL Insurance Company, or its reinsurer(s), any such information. This authorization shall permit the above named company, or its reinsurer(s) or its representative, and any consumer reporting agency to verify my personal information and to view, copy, be furnished copies, or be given details of: (a) medical and other history; (b) mental or physical conditions; (c) evaluation, diagnosis, treatment, and prognosis of mental or physical conditions. Such information shall specifically include psychiatric treatment and drug or alcohol abuse treatment. I authorize MTL Insurance Company or its reinsurer(s) to make a brief report of my personal health information to MIB. I understand that the MIB may exchange my personal health information for remuneration when another MIB member inquires about me. A photocopy of this authorization shall be as valid as the original. This authorization may also be used to verify current address information and shall be in effect for this purpose only until revoked. Otherwise, this authorization expires two years after the date of the policy.

I/We acknowledge receipt of the disclosure statement regarding the investigative consumer report and MIB, Inc., and authorize MTL Insurance Company, or its reinsurer(s), to obtain a consumer investigative report if deemed necessary and to make a brief report regarding information relating to my health and insurability to the MIB.

☐ I elect to be interviewed if a consumer report is prepared in connection with this application. Please contact me between the hours of _____ and _____. Telephone number of Proposed Primary Insured _____ .

Who Must Sign: The Owner; the Insured, if other than the Owner; and any Irrevocable Beneficiary, Creditor Beneficiary, Assignee. Where the signature of a corporation is required, the name of the corporation should be filled in followed by the signature and title of an officer.

Signed at _____ Date _____
(City and State)

_____
Signature of Proposed Primary Insured (Age 15 and over)

_____
Signature of Owner (If other than Proposed Primary Insured)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Grantor (If other than Trustee)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Parent/Legal Guardian (Include Title/Relationship)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Irrevocable Beneficiary or Creditor Beneficiary

_____
Signature of Assignee

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date _____ Signature Witness (Agent) _____

Print Name _____

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This page must be given to the Primary Insured. A copy must also be given to each Additional Insured.

Disclosure Statement

Thank You for your request for a change to your policy. As part of the normal underwriting process, an investigative consumer report may be obtained. This report may include information as to your character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with you and/or friends, neighbors, and associates. Upon written request to our Policy Change Department, a summary of your rights and complete information as to the nature and scope of such report will be provided.

By use of the reports mentioned above, we are able to offer insurance coverage at the lowest possible cost to all who qualify. We appreciate the opportunity of serving your life insurance needs. We want to assure you that your application will receive the most prompt and favorable consideration possible.

Please Note that information regarding your insurability will be treated as confidential. However, MTL Insurance Company or its reinsurer(s) may make a brief report thereon to MIB, Inc. This is a not-for-profit membership organization of life insurance companies. It operates an information exchange on behalf of its members. Upon request by another member insurance company, to which you have applied for life or health insurance coverage or to which a claim is submitted, the MIB will supply that company with information it may have in its files.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact the MIB. You may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; telephone number 866-692-6901 (www.mib.com).

MTL Insurance Company or its reinsurer(s) may also release information in its file directly to other life insurance companies to which you may apply for life or health insurance or to which a claim for benefits may be submitted.

MTL Insurance Company **Oak Brook, Illinois 60523-2269**

MTL Insurance Company

1200 Jorie Boulevard Oak Brook, Illinois 60523-2269

Part II Application for Life Insurance

Answers made to Medical Examiner

(Circle all applicable items and provide details for all "Yes" answers in Question 9.)

	Yes	No
1. Insured or Applicant a. Full Legal Name _____ b. Date of Birth _____		
2. Has the Proposed Insured EVER been advised of, diagnosed, tested positive for, sought consultation for, or been treated for: cancer, stroke or heart attack (heart disease) by a member of the medical profession?	☐	☐
3. Has the Proposed Insured, within the past 10 years, been advised of, diagnosed, tested positive for, sought consultation for, or been treated by a member of the medical profession, for:		
a. Convulsions, seizures, paralysis, mental or nervous disorder, attempted suicide, or recurrent dizziness, fainting or headaches?	☐	☐
b. Asthma, emphysema, tuberculosis, bronchitis or chronic respiratory disorder, sleep apnea or persistent shortness of breath?	☐	☐
c. Chest pain or tightness, palpitations, high blood pressure, heart murmur, other disorder of the heart or blood vessels?	☐	☐
d. Hepatitis, intestinal bleeding, ulcer, colitis, recurrent diarrhea or indigestion, or other disorder of the stomach, intestines, liver or pancreas?	☐	☐
e. Sugar, albumin, blood or pus in urine, venereal disease or other disorder of kidney, bladder, prostate, breasts or reproductive organs?	☐	☐
f. Diabetes, thyroid or other endocrine disorders?	☐	☐
g. Arthritis, or disorder of the muscles, bones, spine, back or joints?	☐	☐
h. Disorder of the skin, lymph glands, cyst or tumor?	☐	☐
i. Disorder of the eyes, anemia or other disorder of the blood?	☐	☐
4. Has the Proposed Insured, within the past 10 years, been medically diagnosed or treated by a physician as having AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or any other immunological disorder?	☐	☐
5. Has the Proposed Insured within the past 10 years:		
a. Used barbiturates, heroin, cocaine, marijuana, or any other illegal or controlled substance, except as prescribed by a physician?	☐	☐
b. Been advised to seek, or received counseling or treatment, or attended or joined any organization for alcohol or drug dependence?	☐	☐
6. Other than above, has the Proposed Insured within the past 5 years:		
a. Been diagnosed or treated for a mental or physical disorder, illness, injury or surgery?	☐	☐
b. Had a checkup or other consultation?	☐	☐
c. Been a patient in a hospital, clinic, medical center or other medical facility?	☐	☐
d. Had an EKG, stress test or any other diagnostic test (not including HIV tests)?	☐	☐
e. Been advised to have any diagnostic test (not including HIV tests), hospitalization or surgery which was not completed?	☐	☐
f. Requested or received a pension, benefits, or payment because of an injury, sickness or disability?	☐	☐
7. Has the Proposed Insured:		
a. Lost or gained more than 15 lbs in the past year? If Yes, indicate reason and amount of gain or loss.	☐	☐
b. Used tobacco or nicotine in any form in the past 12 months?	☐	☐
c. Used tobacco or nicotine in any form in the past 48 months?	☐	☐
8. Is the Proposed Insured currently under observation by a physician or taking any prescription medication(s)?	☐	☐

9. Details of "YES" answers. ***Identify question number and include***: Diagnoses, prescription medication(s), dates, duration, and name and addresses of all attending physicians and medical facilities. If more space is needed, attach on separate page.

Question	Details

10. Primary Care Physician: Name: _____ Phone Number: _____

Address: _____

11. Proposed Insured Family History:

	Yes	No
a. Has any family member been diagnosed with diabetes, cancer, stroke, heart or kidney disease or mental illness? (If Yes, give details including date of diagnosis)	☐	☐

b.

	Age if Living	Cause of Death	Age at Death		Number Living	Number Deceased	Cause of Death	Age at Death
Father				Brothers				
Mother				Sisters				

The undersigned hereby represent(s) that the foregoing statements and answers to the best of our (my) knowledge and belief, as well as any made in continuation hereof, are complete and true, and it is agreed as follows:

1. That all of said statements and answers, including those in continuation hereof, shall constitute the application and form the basis of any policy that may be issued;
2. That the company shall incur no liability under this application until it has been received, approved, a policy issued and delivered and the full first premium has actually been paid to and accepted by the Company, all while the health, occupation and any other conditions relating to each person to be insured are as described in this application, in which case such policy shall take effect as of the date of issue shown therein; **Provided**, however, that if payment is made in exchange for a Conditional Receipt bearing the same date as Part I of this application, insurance shall take effect if the conditions stated in said receipt are satisfied;
3. That if the Company should issue a policy different from that applied for, or in the case of apparent errors or omissions discovered by the Company, the Company is hereby authorized to amend this application by "Home Office Endorsement", and the acceptance of any policy issued on this application shall constitute an approval of the policy provisions and a ratification of such amendment. However, written consent of the Insured and the Applicant, if other than the Insured, may be required for any amendment relating to amount, classification, plan of insurance or benefits.

I/We hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or my health, or of any of my minor children who are to be insured, to give to MTL Insurance Company, or its reinsurer(s), any such information. This authorization shall permit the above named company, or its reinsurer(s) or its representative, and any consumer reporting agency to verify my personal information and to view, copy, be furnished copies, or be given details of: (a) medical and other history; (b) mental or physical conditions; (c) evaluation, diagnosis, treatment, and prognosis of mental or physical conditions. Such information shall specifically include psychiatric treatment and drug or alcohol abuse treatment. A photocopy of this authorization shall be as valid as the original. This authorization expires two years after the date of the policy.

Signed at _____ Date _____ _____

(City and State) Signature of Proposed Primary Insured (Age 15 and over)

_____ _____

Signature of Parent/Legal Guardian (If minor under age 15) (Include Title/Relationship)

Signature of Witness (Medical Examiner)

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Voucher for Medical Examination (*Please Print*) ***Do Not Detach***

Name of person examined _____ Date examined _____ Fee _____

Name of Agent _____

Medical Examiner: Name _____ Phone Number _____

Street Address _____ City _____ State _____ Zip Code _____

Medical Examiner's Report (Both sides of this form are to be completed by the Medical Examiner)

1. a. Height (in shoes) _____ ft. _____ in. Scale Weight (clothed) _____ lbs.

Males Only: Chest (full inspiration) _____ in. Chest (forced expiration) _____ in. Abdomen, at Umbilicus _____ in.

b. Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

c. Is appearance unhealthy or older than stated? ☐ Yes ☐ No

2. Blood Pressure: (If systolic reading over 140 or diastolic over 90, or if Insured is markedly overweight, obtain three readings at intervals.)

	Initial	Additional Readings
Systolic		
Diastolic (5th phase)		

3. Pulse:

	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per minute			

4. Heart: Is there any: Enlargement ☐ Yes ☐ No Murmur(s) ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No Edema ☐ Yes ☐ No

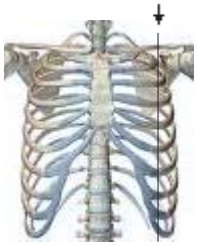
(Describe below - if more than one, describe separately.)

	Location:		Location:	
Constant	☐	☐		
Inconstant	☐	☐		
Transmitted	☐	☐		
Localized	☐	☐		
Systolic	☐	☐		
Presystolic	☐	☐		
Diastolic	☐	☐		
Soft (Gr. 1-2)			☐	☐
Mod. (Gr. 3-4)			☐	☐
Loud (Gr. 5-6)			☐	☐
After Exercise:				
Increased			☐	☐
Absent			☐	☐
Unchanged			☐	☐
Decreased			☐	☐

Indicate:
Apex by X
Murmur area by ☐
Point of greatest intensity by ○
Transmission by →

For comment and your impression:

MCL



5. Is there on examination any abnormality of the following: (Circle applicable items and give details.)

	Yes	No
a. Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
b. Skin (include scars); lymph nodes; varicose veins or peripheral arteries?	☐	☐
c. Nervous system (include reflexes, gait, paralysis, tremors)?	☐	☐
d. Respiratory system?	☐	☐
e. Abdomen (include scars)?	☐	☐
f. Genitourinary system (include prostate)?	☐	☐
g. Endocrine system (include thyroid and breasts)?	☐	☐
h. Musculoskeletal system (include spine, joints, amputation, deformities)?	☐	☐

6. Are there any hernias? ☐ Yes ☐ No

7. Are you aware of additional medical history? (A confidential report may be sent to the Medical Director.) ☐ Yes ☐ No

8. Have you known Insured previously? ☐ Yes ☐ No

9. Details of "Yes" answers. (Identify item.)

10. Urinalysis: Specific Gravity _____ Albumin _____ Sugar _____ Is specimen being sent to Company lab? ☐ Yes ☐ No

Send urine specimen if Insured is applying for $100,000 or more of life insurance, or is (a) hypertensive or has other cardiovascular abnormalities, (b) markedly overweight, or (c) age 60 and over. Send 2 specimens (different days) if albumin, sugar, pus, blood or casts are present, or were found in past.

I have examined the Proposed Insured in private at:

☐ My Office ☐ Proposed Insured's Residence ☐ Proposed Insured's Place of Business ☐ Other _____

At _____ AM / PM _____ _____ M.D.

Time Date Medical Examiner Signature

Policy
Reissue / Change
Supplemental Application

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This Supplement is Part of the Application on the life of _____ Policy Number _____
(Primary Insured's Name)

For a Policy with: ☐ Term Rider Insurance ☐ Children Insurance ☐ Applicant Waiver of Premium

1. Persons Proposed for Coverage (Please Print)

Full Legal Name (First, Middle Initial, Last)	Occupation	Social Security Number	Relationship to Primary Insured	State of Birth	Date of Birth mm/dd/yyyy	Age Nearest Birthday	Sex	Marital Status	Height Ft.	Height In.	Weight
a.											
b.											
c.											
d.											
e.											

2. Does any Proposed Insured have any existing individual life insurance or annuity contracts in force? ☐ Yes ☐ No
(If Yes, give details below)

Name of Proposed Insured	Company Name	Policy Number	Amount	Year Issued	Accidental Death Amount	Annuity	Business Insurance
a.						☐	☐
b.						☐	☐
c.						☐	☐
d.						☐	☐
e.						☐	☐

3. Are all Proposed Insureds citizens of the U.S.A.? If No, provide details, name of person, and the present status. ☐ Yes ☐ No

4. Has any Proposed Insured ever pled guilty to or been convicted of a felony? If Yes, provide details. ☐ Yes ☐ No

5. Beneficiary Designation: Death benefit proceeds are to be paid as follows, unless changed by written request at a later date. Complete address information if other than Primary Insured's address.

Beneficiary(ies) for Insured _____

Primary Full Legal Name _____ Relationship to Insured _____ Date of Birth _____
Street Address _____ City _____ State _____ Zip Code _____

Contingent Full Legal Name _____ Relationship to Insured _____ Date of Birth _____
Street Address _____ City _____ State _____ Zip Code _____

Beneficiary(ies) for Insured _____

Primary Full Legal Name _____ Relationship to Insured _____ Date of Birth _____
Street Address _____ City _____ State _____ Zip Code _____

Contingent Full Legal Name _____ Relationship to Insured _____ Date of Birth _____
Street Address _____ City _____ State _____ Zip Code _____

Unless stated differently above:

- Any Additional Insured's death benefit shall be paid to the Primary Insured if living; if not living, to the estate of the Additional Insured.
- Any Children Insurance Rider death benefit shall be paid to the Primary Insured, if living; if not living, to the Primary Insured's legal Spouse as of the date of death of the Primary Insured, if living; if no spouse, or if not living, to the estate of such Child.
- Beneficiaries of the same class will share equally with the right of survivorship. If a Trustee is named above, payment to such Trustee will discharge the Company from further liability to the extent of that payment.

This Supplement is Part of the Application on the life of: _____

Proposed Insured's Name: _____

Complete a separate page for each Proposed Insured Or if applying for Owner/Applicant Waiver of Premium

(Circle all applicable items and provide details for all "YES" answers in Question 13.)

	Yes	No
6. Has the Proposed Insured EVER been advised of, diagnosed, tested positive for, sought consultation for, or been treated for: cancer, stroke or heart attack (heart disease) by a member of the medical profession?	☐	☐
7. Has the Proposed Insured, within the past 10 years, been advised of, diagnosed, tested positive for, sought consultation for, or been treated by a member of the medical profession, for:		
a. Convulsions, seizures, paralysis, mental or nervous disorder, attempted suicide, or recurrent dizziness, fainting or headaches?	☐	☐
b. Asthma, emphysema, tuberculosis, bronchitis or chronic respiratory disorder, sleep apnea or persistent shortness of breath?	☐	☐
c. Chest pain or tightness, palpitations, high blood pressure, heart murmur, other disorder of the heart or blood vessels?	☐	☐
d. Hepatitis, intestinal bleeding, ulcer, colitis, recurrent diarrhea or indigestion, or other disorder of the stomach, intestines, liver or pancreas?	☐	☐
e. Sugar, albumin, blood or pus in urine, venereal disease or other disorder of kidney, bladder, prostate, breasts or reproductive organs?	☐	☐
f. Diabetes, thyroid or other endocrine disorders?	☐	☐
g. Arthritis, or disorder of the muscles, bones, spine, back or joints?	☐	☐
h. Disorder of the skin, lymph glands, cyst or tumor?	☐	☐
i. Disorder of the eyes, anemia or other disorder of the blood?	☐	☐
8. Has the Proposed Insured, within the past 10 years, been medically diagnosed or treated by a physician as having AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or any other immunological disorder?	☐	☐
9. Has the Proposed Insured within the past 10 years:		
a. Used barbiturates, heroin, cocaine, marijuana, or any other illegal or controlled substance, except as prescribed by a physician?	☐	☐
b. Been advised to seek, or received counseling or treatment, or attended or joined any organization for alcohol or drug dependence?	☐	☐
10. Other than above, has the Proposed Insured within the past 5 years:		
a. Been diagnosed or treated for a mental or physical disorder, illness, injury or surgery?	☐	☐
b. Had a checkup or other consultation?	☐	☐
c. Been a patient in a hospital, clinic, medical center or other medical facility?	☐	☐
d. Had an EKG, stress test or any other diagnostic test (not including HIV tests)?	☐	☐
e. Been advised to have any diagnostic test (not including HIV tests), hospitalization or surgery which was not completed?	☐	☐
f. Requested or received a pension, benefits, or payment because of an injury, sickness or disability?	☐	☐
11. Has the Proposed Insured:		
a. Lost or gained more than 15 lbs in the past year? If Yes, indicate reason and amount of gain or loss.	☐	☐
b. Used tobacco or nicotine in any form in the past 12 months?	☐	☐
c. Used tobacco or nicotine in any form in the past 48 months?	☐	☐
12. Is the Proposed Insured currently under observation by a physician or taking any prescription medication(s)?	☐	☐

13. Details of "YES" answers. ***Identify question number and include***: Diagnoses, prescription medication(s), dates, duration, and name and addresses of all attending physicians and medical facilities.

Question	Details

14. Primary Care Physician: Name: _____ Phone Number: _____

Address: _____

15. Proposed Insured Family History:

	Yes	No
a. Has any family member been diagnosed with diabetes, cancer, stroke, heart or kidney disease or mental illness? (If Yes, give details including date of diagnosis)	☐	☐

b.

	Age if Living	Cause of Death	Age at Death		Number Living	Number Deceased	Cause of Death	Age at Death
Father				Brothers				
Mother				Sisters				

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The undersigned hereby represent(s) that the foregoing statements and answers to the best of our (my) knowledge and belief, as well as any made in continuation hereof, are complete and true, and it is agreed as follows:

1. That all of said statements and answers, including those in continuation hereof, shall constitute the application and form the basis of any policy change that may be issued;
2. That the company shall incur no liability under this application until it has been received, approved, and any necessary premium has actually been paid to and accepted by the Company, all while the health, occupation and any other conditions relating to each person to be insured are as described in this application, in which case such policy change shall take effect as of the date shown therein;
3. That if the Company should issue a policy change different from that applied for, or in the case of apparent errors or omissions discovered by the Company, the Company is hereby authorized to amend this application by "Home Office Endorsement," and the acceptance of any policy change issued on this application shall constitute an approval of the policy provisions and a ratification of such amendment. However, written consent of the Insured and the Applicant, if other than the Insured, may be required for any amendment relating to amount, classification, plan of insurance or benefits.

I/We hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. or other organization, institution or person, that has any records or knowledge of me or my health, or of any of my minor children who are to be insured, to give to MTL Insurance Company, or its reinsurer(s), any such information. This authorization shall permit the above named company, or its reinsurer(s) or its representative, and any consumer reporting agency to verify my personal information and to view, copy, be furnished copies, or be given details of: (a) medical and other history; (b) mental or physical conditions; (c) evaluation, diagnosis, treatment, and prognosis of mental or physical conditions. Such information shall specifically include psychiatric treatment and drug or alcohol abuse treatment. I authorize MTL Insurance Company or its reinsurer(s) to make a brief report of my personal health information to MIB. I understand that the MIB may exchange my personal health information for remuneration when another MIB member inquires about me. A photocopy of this authorization shall be as valid as the original. This authorization may also be used to verify current address information and shall be in effect for this purpose only until revoked. Otherwise, this authorization expires two years after the date of the policy.

I/We acknowledge receipt of the disclosure statement regarding the investigative consumer report and MIB, Inc., and authorize MTL Insurance Company, or its reinsurer(s), to obtain a consumer investigative report if deemed necessary and to make a brief report regarding information relating to my health and insurability to the MIB.

☐ I elect to be interviewed if a consumer report is prepared in connection with this application. Please contact me between the hours of _____ and _____. Telephone number of Proposed Primary Insured _____ .

Who Must Sign: The Owner; the Insured, if other than the Owner; and any Irrevocable Beneficiary, Creditor Beneficiary, Assignee. Where the signature of a corporation is required, the name of the corporation should be filled in followed by the signature and title of an officer.

Signed at _____ Date _____
(City and State)

_____
Signature of Proposed Primary Insured (Age 15 and over)

_____
Signature of Owner (If other than Proposed Primary Insured)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Grantor (If other than Trustee)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Parent/Legal Guardian (Include Title/Relationship)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Irrevocable Beneficiary or Creditor Beneficiary

_____
Signature of Assignee

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date _____ Signature Witness (Agent) _____

Print Name _____

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This page must be given to the Primary Insured. A copy must also be given to each Additional Insured.

Disclosure Statement

Thank You for your request for a change to your policy. As part of the normal underwriting process, an investigative consumer report may be obtained. This report may include information as to your character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with you and/or friends, neighbors, and associates. Upon written request to our Policy Change Department, a summary of your rights and complete information as to the nature and scope of such report will be provided.

By use of the reports mentioned above, we are able to offer insurance coverage at the lowest possible cost to all who qualify. We appreciate the opportunity of serving your life insurance needs. We want to assure you that your application will receive the most prompt and favorable consideration possible.

Please Note that information regarding your insurability will be treated as confidential. However, MTL Insurance Company or its reinsurer(s) may make a brief report thereon to MIB, Inc. This is a not-for-profit membership organization of life insurance companies. It operates an information exchange on behalf of its members. Upon request by another member insurance company, to which you have applied for life or health insurance coverage or to which a claim is submitted, the MIB will supply that company with information it may have in its files.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact the MIB. You may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; telephone number 866-692-6901 (www.mib.com).

MTL Insurance Company or its reinsurer(s) may also release information in its file directly to other life insurance companies to which you may apply for life or health insurance or to which a claim for benefits may be submitted.

MTL Insurance Company **Oak Brook, Illinois 60523-2269**

SERFF Tracking Number:	*MTLC-128335519*	*State:*	*Arkansas*
Filing Company:	*MTL Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*6300-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2012 Applications*		
Project Name/Number:	*/*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
Certification of Readability- App.pdf

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: Application filing
Comments:

CERTIFICATE OF READABILITY

MTL Insurance Company by Roger L. Barth, Vice President, Product Development, does hereby certify that the accompanying forms identified by the listing below, have the scores listed, which were calculated using the Flesch Reading Ease Test, and are readable under the standards of said test.

FORM	FLESCH SCORE
2752-12	53.20
6300-12	55.60
6328-12	50.00
6329-12	51.10
6330-12	55.80
6331-12	52.10

MTL INSURANCE COMPANY

By: Roger L. Barth

Digitally signed by Roger L. Barth
DN: cn=Roger L. Barth, o=MTL Insurance Co, ou=Vice President, Product Development, email=barthr@mutualtrust.com, c=US
Date: 2012.05.04 15:27:25 -05'00'

Roger L. Barth, FSA, MAAA
Vice President

Dated: May 4, 2012

SERFF Tracking Number:	*MTLC-128335519*	*State:*	*Arkansas*
Filing Company:	*MTL Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*6300-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*2012 Applications*		
Project Name/Number:	*/*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/04/2012	Form	Life Insurance Application	05/30/2012	6300-12 V.1.pdf (Superceded)
05/04/2012	Form	Policy Term Conversion/Purchase Option Application	05/30/2012	6328-12 V.1.pdf (Superceded)
05/04/2012	Form	Policy Reissue/Change Application	05/30/2012	6329-12 V.1.pdf (Superceded)
05/04/2012	Form	Policy Reissue/Change Supplemental Application	05/30/2012	6331-12 V.1.pdf (Superceded)
05/04/2012	Form	Policy Reinstatement Application	05/30/2012	2752-12 V.1.pdf (Superceded)

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Application for Life Insurance

Instructions:

1. All questions must be answered. Any changes must be initialed by the Applicant. Lines drawn through questions and "N/A" are not acceptable; "**None**" must be used instead.

2. ***Owner's*** and ***Co-Owner's,*** if applicable, ***Taxpayer Identification Number*** must be provided on the Application (Questions 4c and 4i). If the Owner is other than the Insured, the Owner's signature is required. Each Owner must also complete and sign Page 11.

3. Medical Questions 21-30 **must** be completed for every Proposed Insured, even though a medical or paramedical examination is required. Failure to do so may result in an unnecessary delay. A separate Page 7 should be completed for each Proposed Insured.

Table of Contents

Signature(s) Required

How to speed your case through Underwriting

1. Complete all forms legibly and fully. Leaving blanks causes delays and often requires an amendment on delivery.

2. Schedule any necessary requirements, such as an exam, EKG, blood and urine tests promptly.

3. Give full names and addresses for any doctors named in this application, including phone numbers.

4. Track your applications through our Pending Application Summary Report available on our agent web site at https://agent.mutualtrust.com.

5. Fax completed applications to **800-522-0449**. If faxing the application, please do not mail the original application to the Home Office.

Conditional Receipt

Received from _____ a check in the amount of $ _____ paid with this insurance application to MTL Insurance Company. The Application bears the same date as this Receipt. I have advised each proposed insured and owner of the terms, conditions, and limitations of this Conditional Receipt. No agent is authorized to alter the terms of this Receipt, waive any terms, requirements or conditions, or pass on insurability.

Agent Signature _____ Date _____

TERMS, CONDITIONS AND LIMITS: The life insurance you applied for will not provide insurance coverage unless a contract is delivered to you. However, subject to the terms, conditions, and limitations of this Receipt, conditional insurance as provided by the terms and conditions of the policy/certificate applied for will become effective as of the Effective Date, which shall be the **latest** date of the following events:

- Signing of all parts of the Application, including any supplement, addenda, or amendment to the Application, and completion of any medical examination portion of the application;
- Date requested in the Application that is agreed to by the Insurer;
- The full initial premium for mode of payment chosen is received at our Home Office;
- Any additional information required by us, including attending physician statements/reports, is received at our Home Office.

This Receipt will provide no life insurance unless **each** of the following requirements are fulfilled during the lifetime of the person(s) proposed to be insured:

- As of the Effective Date, each person proposed to be insured is found to be insurable exactly as applied for in the Application pursuant to the Insurer's underwriting rules and standards, without any modification as to this insurance product, amount of insurance coverage, or premium rate;
- The payment taken with the Application is not less than the full initial premium for the mode of payment chosen and is honored immediately upon presentation;
- All medical information required by the Insurer is received at the Insurer's Home Office within 60 days of the completion of the Application.

If all requirements are not met, or the person(s) to be insured dies by suicide, the insurer's liability shall be limited to a full premium refund.

The aggregate amount of life insurance provided on the life of any person proposed to be insured which may become effective under this Receipt shall be the **lesser** of the amount applied for or $250,000.00.

All premium checks must be made payable to the MTL Insurance Company. DO NOT make any check payable to the agent or leave the payee blank. We do not accept third party checks, cashier checks, money orders or cash.

MTL Insurance Company **Oak Brook, Illinois 60523-2269**

Disclosure Statement

This section must be detached and given to the Primary Insured. A copy must also be given to each Additional Insured.

Thank You for your application for insurance. As part of the normal underwriting process, an investigative consumer report may be obtained. This report may include information as to your character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with you and/or friends, neighbors, and associates. Upon written request to our New Business Department, a summary of your rights and complete information as to the nature and scope of such report will be provided.

By use of the reports mentioned above, we are able to offer insurance coverage at the lowest possible cost to all who qualify. We appreciate the opportunity of serving your life insurance needs. We want to assure you that your application will receive the most prompt and favorable consideration possible.

Please Note that information regarding your insurability will be treated as confidential. However, MTL Insurance Company or its reinsurer(s) may make a brief report thereon to the Medical Information Bureau ("MIB"). This is a non-profit membership organization of life insurance companies. It operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, the MIB will supply that company with information it may have in its files.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact the MIB. You may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734; telephone number 866-692-6901 (www.mib.com).

MTL Insurance Company or its reinsurer(s) may also release information in its file directly to other life insurance companies to which you may apply for life or health insurance or to which a claim for benefits may be submitted.

MTL Insurance Company **Oak Brook, Illinois 60523-2269**

MTL Insurance Company

1200 Jorie Boulevard Oak Brook, Illinois 60523-2269

Part I Application for Life Insurance

1. Persons Proposed for Coverage (Please Print)

Full Legal Name (First, Middle Initial, Last)	Occupation	Social Security Number	Relationship to Primary Insured	State of Birth	Date of Birth mm/dd/yyyy	Age Nearest Birthday	Sex	Marital Status	Height Ft.	Height In.	Weight
a.			Primary Insured								
b.											
c.											
d.											
e.											

2. Primary Insured's Residence Address (Provide addresses for 5 years - current first, then most recent former, etc.)

Street Address or Rural Route (No PO Boxes)	City and State	Zip Code	Phone Number	Time There Yrs. Mos.
			Not Applicable	
			Not Applicable	

3. Primary Insured's Business Address (Present employer first, then most recent former employer)

a. Employer	Street Address	City and State	Zip Code	Phone Number	Time There Yrs. Mos.
				Not Applicable	

b. Gross Annual Earned Income $ _____

c. Total Gross Household Annual Earned Income $ _____

4. Ownership (Complete if other than Primary Insured)

Owner

a. Full Legal Name _____ Date of Birth _____

b. Relationship to Insured _____

c. Taxpayer Identification Number* _____ ☐ Individual (SSN) ☐ Corporation ☐ Partnership ☐ Trust

Grantor of Trust (If no Trust TIN) _____ Taxpayer Identification Number _____

d. Owner Street Address _____

City _____ State _____ Zip Code _____ Phone Number _____

e. Secondary Address (for notification of past due premiums and possible lapse in coverage)

Street Address _____

City _____ State _____ Zip Code _____ Phone Number _____

f. E-Mail Address _____

Co-Owner (if applicable)

g. Full Legal Name _____ Date of Birth _____

h. Relationship to Insured _____

i. Taxpayer Identification Number* _____ ☐ Individual (SSN) ☐ Corporation ☐ Partnership ☐ Trust

Grantor of Trust (If no Trust TIN) _____ Taxpayer Identification Number _____

j. Owner Street Address _____

City _____ State _____ Zip Code _____ Phone Number _____

k. Secondary Address (for notification of past due premiums and possible lapse in coverage)

Street Address _____

City _____ State _____ Zip Code _____ Phone Number _____

l. E-Mail Address _____

* If Ownership is a Trust, enter the Trust Taxpayer Identification Number. If no Trust TIN, enter Grantor's Taxpayer Identification Number.

5. Contingent Ownership Upon death, the rights of the deceased Owner shall pass to the Owner's estate, unless otherwise stated below.

a. Full Legal Name _____ Relationship to Insured _____ Date of Birth _____

b. Taxpayer Identification Number* _____ ☐ Individual (SSN) ☐ Corporation ☐ Partnership ☐ Trust

If Trust, Grantor Name _____ Taxpayer Identification Number _____

c. Owner Street Address _____

City _____ State _____ Zip Code _____ Phone Number _____

* If Ownership is a Trust, enter the Trust Taxpayer Identification Number. If not assigned, enter Grantor's Taxpayer Identification Number.

6. Plan of Insurance

Traditional Life

Plan _____

☐ Base Face Amount $ _____

☐ Money Purchase $ _____ Premium

☐ Automatic Premium Payment Provision (permanent plans only)

☐ Accelerated Death Benefit Rider

☐ Waiver of Premium - "Own Occupation" ☐ 2 year or ☐ 5 year

☐ Owner / Applicant Waiver of Premium - Primary Insured under Age 15. Include Owner / Applicant when answering all Questions.

☐ Single Premium Paid Up Insurance Rider

☐ Face Amount Or ☐ Premium $ _____

☐ Flexible Premium Paid Up Insurance Rider

Initial Premium $ _____

Maximum Annual Premium $ _____

Stipulated Annual Premium $ _____

Years Payable _____

☐ Disability Benefit Rider

Annual Benefit Amount $ _____

Benefit Period _____ (in years)

Flexible Premium Adjustable Life (Universal Life)

Plan _____

Initial Face Amount $ _____

Planned Annual Premium $ _____

☐ Waiver of Monthly Deduction Rider

Death Benefit Option (choose one)

☐ (A) Face Amount plus Account Value

☐ (B) Face Amount

☐ (C) Face Amount, plus Paid Premiums, minus Partial Withdrawals

No Lapse Period (choose one)

☐ 20 Year ☐ 30 Year ☐ 40 Year

Death Benefit Calculation Test (choose one)

☐ Guideline Premium

☐ Cash Value Accumulation

Additional Riders and Benefits - All Plans

☐ Accidental Death $ _____

☐ Children Insurance $ _____

☐ Purchase Option $ _____

☐ _____

☐ _____

☐ Term Insurance Rider

Proposed Insured's Name	Type	Amount

7. Dividend Options

Traditional Life

☐ Buy Paid Up Additions ☐ Accumulate at Interest ☐ Paid in Cash

☐ Apply Toward Premium ☐ Buy One Year Term Only

☐ Maximum Accumulation (Flexible Premium PUA Rider required)

☐ One Year Term (Equal to the cash value of the basic plan)

☐ One Year Term / PUA's (Modified Whole Life Plans only)

☐ _____

Flexible Premium Adjustable Life Plans

☐ Paid in Cash

☐ Apply Toward Account Value

8. Mode of premium payment desired

☐ Pre-Authorized Payment Plan ☐ Quarterly ☐ Semi-Annual ☐ Annual ☐ Other _____

9. Does any Proposed Insured have any existing individual life insurance or annuity contracts in force? ☐ Yes ☐ No

(If Yes, give details below)

	Name of Proposed Insured	Company Name	Policy Number	Amount	Year Issued	Accidental Death Amount	Annuity	Business Insurance
a.							☐	☐
b.							☐	☐
c.							☐	☐
d.							☐	☐
e.							☐	☐

10. Has any Proposed Insured, within the last ten years, been declined, postponed or refused reinstatement for life or health insurance or been offered a policy with an extra premium or otherwise not as applied for? ☐ Yes ☐ No
If Yes, state person, company, date and details.

11. Are any other applications for insurance on the life of any Proposed Insured now pending or contemplated? ☐ Yes ☐ No
If Yes, state amount, person, company, and details, including if all policies will be placed in force.

12. Is this policy applied for intended to replace existing life insurance or annuities on the life of any Proposed Insured? ☐ Yes ☐ No

a. If Yes, provide company, person, policy number, amount, type, and date of policies.

_____

b. If Yes, and replacement is also a 1035 Exchange: Estimated Amount $_____

13. Has any Proposed Insured within the past five years:

a. Engaged in any kind of Racing, Underwater Diving, Sky Diving, Parachuting, Ballooning, Hang Gliding, Climbing or Mountaineering, or does any Proposed Insured intend to do so in the next two years? If Yes, complete the Avocation Supplement. ☐ Yes ☐ No

b. Been convicted of driving while intoxicated or reckless driving or of two or more other moving violations, or had a driver's license suspended or revoked? If Yes, provide details and name of person. ☐ Yes ☐ No

_____

c. Provide the following information for any Proposed Insured. If Owner is other than Primary Insured, provide driver's license or identification number.

Name _____ Lic / ID No. _____ State _____ Exp Date _____

Name _____ Lic / ID No. _____ State _____ Exp Date _____

Name _____ Lic / ID No. _____ State _____ Exp Date _____

Name _____ Lic / ID No. _____ State _____ Exp Date _____

Name _____ Lic / ID No. _____ State _____ Exp Date _____

14. Are all Proposed Insureds citizens of the U.S.A.? If No, provide details, name of person, and the present status. ☐ Yes ☐ No

15. Has any Proposed Insured ever pled guilty to or been convicted of a felony? If Yes, provide details. ☐ Yes ☐ No

16. Has any Proposed Insured, within the past three years, flown in any type of aircraft as a pilot, student pilot or crew member, or does any Proposed Insured intend to do so in the next two years? If Yes, complete Aviation Supplement. ☐ Yes ☐ No

17. Does any Proposed Insured contemplate leaving the U.S.A. for travel or residence in the next two years? ☐ Yes ☐ No
If Yes, provide details.

18. Has any Proposed Insured or his/her company filed for bankruptcy within the past five years? If Yes, provide details and dates. ☐ Yes ☐ No

19. Beneficiary Designation

a. Death benefit proceeds are to be paid as follows, unless changed by written request at a later date. Complete address information if other than Primary Insured's address.

Beneficiary(ies) for Primary Insured

Primary Full Legal Name _____ Relationship to Insured _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Full Legal Name _____ Relationship to Insured _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Contingent Full Legal Name _____ Relationship to Insured _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Full Legal Name _____ Relationship to Insured _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Beneficiary(ies) for Insured _____

Primary Full Legal Name _____ Relationship to Insured _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Contingent Full Legal Name _____ Relationship to Insured _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Beneficiary(ies) for Insured _____

Primary Full Legal Name _____ Relationship to Insured _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Contingent Full Legal Name _____ Relationship to Insured _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Unless stated differently above:

- Any Additional Insured's death benefit shall be paid to the Primary Insured if living; if not living, to the estate of the Additional Insured.
- Any Children Insurance Rider death benefit shall be paid to the Primary Insured, if living; if not living, to the Primary Insured's legal Spouse as of the date of death of the Primary Insured, if living; if no spouse, or if not living, to the estate of such Child.
- Beneficiaries of the same class will share equally with the right of survivorship. If a Trustee is named above, payment to such Trustee will discharge the Company from further liability to the extent of that payment.

b. Child's Share to Trustee: Any payment which becomes due a child under the age of majority shall be paid, not to the child, but to the following as trustee for the child.

Full Legal Name of Trustee _____ Relationship to Insured _____

Street Address _____ City _____ State _____ Zip Code _____

20. Remarks

Home Office use only

Question Number	Name of Person	Details

 Proposed Insured: _____

Complete a separate page for each Proposed Insured or if applying for Owner/Applicant Waiver of Premium

Circle all applicable items and provide details for all "YES" answers in Question 28.

	Yes	No
21. Has the Proposed Insured EVER been advised of, diagnosed, tested positive for, sought consultation for, or been treated for: cancer, stroke or heart attack (heart disease) by a member of the medical profession?	☐	☐
22. Has the Proposed Insured, within the past 10 years, been advised of, diagnosed, tested positive for, sought consultation for, or been treated by a member of the medical profession, for:		
a. Convulsions, seizures, paralysis, mental or nervous disorder, attempted suicide, or recurrent dizziness, fainting or headaches?	☐	☐
b. Asthma, emphysema, tuberculosis, bronchitis or chronic respiratory disorder, sleep apnea or persistent shortness of breath?	☐	☐
c. Chest pain or tightness, palpitations, high blood pressure, heart murmur, other disorder of the heart or blood vessels?	☐	☐
d. Hepatitis, intestinal bleeding, ulcer, colitis, recurrent diarrhea or indigestion, or other disorder of the stomach, intestines, liver or pancreas?	☐	☐
e. Sugar, albumin, blood or pus in urine, venereal disease or other disorder of kidney, bladder, prostate, breasts or reproductive organs?	☐	☐
f. Diabetes, thyroid or other endocrine disorders?	☐	☐
g. Arthritis, or disorder of the muscles, bones, spine, back or joints?	☐	☐
h. Disorder of the skin, lymph glands, cyst or tumor?	☐	☐
i. Disorder of the eyes, anemia or other disorder of the blood?	☐	☐
23. Has the Proposed Insured, within the past 10 years, been medically diagnosed or treated by a physician as having AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or any other immunological disorder?	☐	☐
24. Has the Proposed Insured within the past 10 years:		
a. Used barbiturates, heroin, cocaine, marijuana, or any other illegal or controlled substance, except as prescribed by a physician?	☐	☐
b. Been advised to seek, or received counseling or treatment, or attended or joined any organization for alcohol or drug dependence?	☐	☐
25. Other than above, has the Proposed Insured within the past 5 years:		
a. Been diagnosed or treated for a mental or physical disorder, illness, injury or surgery?	☐	☐
b. Had a checkup or other consultation?	☐	☐
c. Been a patient in a hospital, clinic, medical center or other medical facility?	☐	☐
d. Had an EKG, stress test or any other diagnostic test (not including HIV tests)?	☐	☐
e. Been advised to have any diagnostic test (not including HIV tests), hospitalization or surgery which was not completed?	☐	☐
f. Requested or received a pension, benefits, or payment because of an injury, sickness or disability?	☐	☐
26. Has the Proposed Insured:		
a. Lost or gained more than 15 lbs in the past year? If Yes, indicate reason and amount of gain or loss.	☐	☐
b. Used tobacco or nicotine in any form in the past 12 months?	☐	☐
c. Used tobacco or nicotine in any form in the past 48 months?	☐	☐
27. Is the Proposed Insured currently under observation by a physician or taking any prescription medication(s)?	☐	☐

28. Details of "YES" answers. ***Identify question number and include***: Diagnoses, prescription medication(s), dates, duration, and name and addresses of all attending physicians and medical facilities. If additional space is needed, use Question 20.

Question	Details

29. Primary Care Physician: Name: _____ Phone Number: _____

Address: _____

30. Proposed Insured Family History:

	Yes	No
a. Has any family member been diagnosed with diabetes, cancer, stroke, heart or kidney disease or mental illness? (If Yes, give details including date of diagnosis)	☐	☐

b.

	Age if Living	Cause of Death	Age at Death		Number Living	Number Deceased	Cause of Death	Age at Death
Father				Brothers				
Mother				Sisters				

The applicant has made a payment of $_____, for which a Conditional Receipt, bearing the same date as this application, has been issued, and the terms and conditions of said Conditional Receipt are hereby accepted. (Do not insert amount unless payment is actually made.)

The undersigned hereby represent(s) that the foregoing statements and answers to the best of our (my) knowledge and belief, as well as any made in continuation hereof, are complete and true, and it is agreed as follows:

1. That all of said statements and answers, including those in continuation hereof, shall constitute the application and form the basis of any policy that may be issued;
2. That the company shall incur no liability under this application until it has been received, approved, a policy issued and delivered and the full first premium has actually been paid to and accepted by the Company, all while the health, occupation and any other conditions relating to each person to be insured are as described in this application, in which case such policy shall take effect as of the date of issue shown therein; **Provided**, however, that if payment is made in exchange for a Conditional Receipt bearing the same date as Part I of this application, insurance shall take effect if the conditions stated in said receipt are satisfied;
3. That if the Company should issue a policy different from that applied for, or in the case of apparent errors or omissions discovered by the Company, the Company is hereby authorized to amend this application by "Home Office Endorsement", and the acceptance of any policy issued on this application shall constitute an approval of the policy provisions and a ratification of such amendment. However, written consent of the Insured and the Applicant, if other than the Insured, may be required for any amendment relating to amount, classification, plan of insurance or benefits.

I/We hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health, or of any of my minor children who are to be insured, to give to MTL Insurance Company, or its reinsurer(s), any such information. This authorization shall permit the above named company, or its reinsurer(s) or its representative, and any consumer reporting agency to verify my personal information and to view, copy, be furnished copies, or be given details of: (a) medical and other history; (b) mental or physical conditions; (c) evaluation, diagnosis, treatment, and prognosis of mental or physical conditions. Such information shall specifically include psychiatric treatment and drug or alcohol abuse treatment. I authorize MTL Insurance Company or its reinsurer(s) to make a brief report of my personal health information to MIB. I understand that the MIB may exchange my personal health information for remuneration when another MIB member inquires about me. A photocopy of this authorization shall be as valid as the original. This authorization may also be used to verify current address information and shall be in effect for this purpose only until revoked. Otherwise, this authorization expires two years after the date of the policy.

I/We acknowledge receipt of the disclosure statement regarding the investigative consumer report and the MIB, and authorize MTL Insurance Company, or its reinsurer(s), to obtain a consumer investigative report if deemed necessary and to make a brief report regarding information relating to my health and insurability to the MIB.

☐ I elect to be interviewed if a consumer report is prepared in connection with this application. Please contact me between the hours of _____ and _____. Telephone number of Proposed Primary Insured _____

Who Must Sign: The Owner; the Insured, if other than the Owner; and any Irrevocable Beneficiary. Where the signature of a corporation is required, the name of the corporation should be filled in followed by the signature and title of an officer.

Signed at _____ Date _____ _____
(City and State) Signature of Proposed Primary Insured (Age 15 and over)

_____ _____
Signature of Owner (If other than Proposed Primary Insured) Signature of Other Proposed Insured (Age 15 and over)

_____ _____
Signature of Grantor (If other than Trustee) Signature of Other Proposed Insured (Age 15 and over)

_____ _____
Signature of Irrevocable Beneficiary Signature of Other Proposed Insured (Age 15 and over)

_____ _____
Signature of Parent/Legal Guardian (Include Title/Relationship) Signature of Witness (Agent)

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AGENT'S CERTIFICATION: To the best of my knowledge, a replacement of life insurance or annuities ☐ is ☐ is not involved in this transaction. I also certify that prior to signing this application, I delivered to the Applicant any proposal, outline of coverage, Buyer's Guide, comparison and/or disclosure statement required by Federal Law or by the law in the state where this application was signed.

Date _____ Signature of Agent _____

Print Name _____

Writing Agent Must Complete This Form

Agent's Report

MTL Insurance Company

1. What is the purpose of this insurance? ☐ Executive Bonus ☐ Key Person ☐ Buy / Sell ☐ Deferral ☐ Creditor ☐ Estate Liquidity ☐ Personal ☐ Other _____

2. Personal Finances:
   a. Total Assets: $ _____ b. Total Liabilities: $ _____ c. Net Worth: $ _____
   d. Unearned Income: $ _____ e. Tax Status: _____
   f. Owner's Financial Objectives: _____
   g. Other information affecting Owner's decision to purchase this policy: _____

   If face amount applied for <u>exceeds</u> one million dollars, submit a current Personal Financial Questionnaire Form 4510.

3. Business Finances ***(Complete only if this is Business Insurance)***:
   a. Total Assets: $ _____ b. Total Liabilities: $ _____ c. Net Worth: $ _____
   d. Net Profit after Taxes for Past Two Years: Last Year $ _____ Previous Year $ _____
   e. What is the Proposed Insured's percentage of ownership in this firm? _____
   f. Is there business insurance applied for or in force on other key members of this firm? If Yes or No, provide details. ☐ Yes ☐ No

   _____

   g. Type of Business ☐ Sole Owner ☐ Partnership ☐ Corporation ☐ Other _____

   If face amount applied for <u>exceeds</u> one million dollars - Submit Business Financial Questionnaire Form 4513 along with the required business financial statements.

4. How long and how well have you known the Proposed Insured? (If related, provide details) _____

5. Are you aware of anything about the health, habits, or avocations, which may affect the insurability of any person proposed for insurance? If Yes, provide full details in Question 13. ☐ Yes ☐ No

6. If Insured is married: (a) Spouse's name _____ (b) How much insurance on spouse? _____
   (c) If no insurance, explain. _____

7. If Insured is under age 15: Indicate amount of insurance on each parent and each sibling in Question 13.

8. Additional <u>Or</u> Alternate policy requests (maximum of two) - Policy to be same as original, except for the following:

To be Placed as follows:	a. ☐ Addition to Original ☐ Instead of Original	b. ☐ Addition to Original ☐ Instead of Original
HO Use Only a. _____ b. _____	Amount $ _____ Plan: _____ Benefits: _____ Other: _____	Amount $ _____ Plan: _____ Benefits: _____ Other: _____

9. Agent Information:
   a. Writing Agent: Name _____ Code _____ _____ %
   b. If case is to be shared with other licensed and contracted agent(s), complete the following: +

   % must be whole number and at least 10%

   Name _____ Code _____ _____ %
   Name _____ Code _____ _____ %
   Name _____ Code _____ _____ %
   100 %

10. Agent's phone number: _____

11. Was a sales concept used in this sale? If Yes, indicate below. ☐ Yes ☐ No
    ☐ IBC ☐ Circle of Wealth ☐ LEAP ☐ Other _____

12. Issue Instructions: ☐ Call for Instructions ☐ Companion File(s) _____

13. Remarks and special requests:

CERTIFICATE: I was ☐ or was not ☐ personally in the presence of the Insured(s) when this application was completed and signed. Answers to all questions are properly recorded and, to the best of my knowledge, are complete and true. I represent that I have only used company-approved material and copies of all sales material were left with the applicant. I gave the Proposed Insured(s) the consumer notice regarding the MIB and Fair Credit Reporting Act. I have reasonable grounds for believing that the recommendation is suitable on the basis of facts disclosed. I recommend acceptance at standard rates and without restriction, except as stated above.

Date _____ Writing Agent Signature _____

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Authorization for Release of Medical Information for the purpose of applying for life insurance

This authorization complies with the HIPAA Privacy Rules

Name of Proposed Insured/Patient:

_____

(Last) (First) (Middle) (Maiden) (Date of Birth)

I/We authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record, including my prescription drug history, and any other protected health information concerning me to MTL Insurance Company ("the Company") and its agents, employees, and representatives including retrieval service companies. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By signing below, I/we acknowledge that any agreements I/we have made to restrict our protected health information do not apply to this authorization and we instruct any physician, health care professional, hospital, clinic, laboratory, pharmacy, Pharmacy Benefit Manager, medical facility, or other health care provider to release and disclose our entire medical record without restriction.

I/We understand this authorization is voluntary and that such information will be used by the Company for the purpose of evaluating my application for life insurance. Further, I understand that my authorization is required for the Company to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and no longer protected by the federal privacy laws or required by law.

I/We understand this consent may be revoked in writing at anytime. This consent may not be revoked to the extent that disclosure of information has already occurred, prior to the receipt of revocation by the Proposed Insured(s). Authorization will be considered valid for a period of time not to exceed 24 months from the date that this authorization was signed. A photocopy of this authorization is to be considered as valid as the original. A copy of this authorization will be provided by the Company upon request.

IMPORTANT: This authorization must be signed and dated by all Applicants as required. (This includes your spouse and all dependents age 15 or over who are applying for coverage.) Missing signatures or dates may cause a delay in processing.

_____ _____
Signature of Proposed Primary Insured (Age 15 and over) Mo. Day Yr.

_____ _____
Signature of Spouse (Only if to be Insured) Mo. Day Yr.

_____ _____
Signature of Parent / Legal Guardian (If minor under age 15) Mo. Day Yr.
(Include Title and Relationship)

_____ _____
Signature of Other Proposed Insured (Age 15 or over) Mo. Day Yr.

_____ _____
Signature of Other Proposed Insured (Age 15 and over) Mo. Day Yr.

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Request for Owner Taxpayer Identification Number and Certification

Taxpayer Information

Full Legal Name _____ Date of Birth (if individual) _____

Business Name / Disregarded Entity Name* (if different from above) _____

☐ Individual/Sole Proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited Liability Company. Enter the tax classification (C = C corporation, S = S corporation, P = partnership) ____ ☐ Exempt payee

☐ Other _____

Taxpayer Identification Number (TIN)

The TIN provided must match the name given on the "Full Legal Name" line to avoid backup withholding.

Select and enter your TIN*

- Individuals - this is your social security number
- Sole Proprietor - this is your social security number. (The IRS will also accept your employer identification number.)
- Disregarded Entity - this is your social security number.
- Other entities - this is your employer identification number.

☐ Social Security Number **or** ☐ Employer Identification Number TIN _____

Certification

Under penalties of perjury, I certify that;

1. The number shown on this form is my correct taxpayer identification number; and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends; or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am an individual who is U. S. citizen or U.S. resident alien; a partnership, corporation, company, or association created or organized in the United States or under the laws of the United States; an estate (other than a foreign estate); or a domestic trust (as defined in Regulations section 301.7701-7).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you **are** currently subject to backup withholding because you have failed to report all interest or dividends on your tax return.*

_____ _____
Date Signed Signature of Policyowner

_____
Title (if Corporation / Partnership / Trustee)

* Please refer to Form W-9 Instructions at www.irs.gov

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Authorization for Disclosure of Information for Underwriting Purposes

I, the undersigned, authorize MTL Insurance Company (MTL) to disclose certain personal and confidential information to my MTL agent and his or her agency for the purpose of reviewing this information and explaining MTL's underwriting procedures and decisions or other insurance related actions concerning my application. I understand that the information covered by this Authorization includes personal information, including, but not limited to, health information about me collected by MTL in the course of its underwriting practices.

I understand that MTL's employees, agents, and representatives are required to adhere to the HIPAA policies and are to receive and use personal information for the express purposes of processing my insurance application along with any other necessary and related insurance practices.

I also understand that I may revoke this Authorization at any time by sending MTL written notification of my revocation, except to the extent of any action taken or information received in reliance on this Authorization prior to MTL's receipt of the revocation. If this Authorization is for someone other than myself, that individual and my authority to act on his/her behalf are explained below. Any information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected.

This Authorization is valid for a period of twenty-four (24) months from the date of my signature below. A copy of this Authorization may be used in place of the original.

_____

Name of Individual Whose Information is Covered by this Authorization *(Please Print)*

_____ _____

Signature of Individual or Representative Date

_____

Name of Representative with Authority to Act on Behalf of the Individual Whose Information is Covered by this Authorization, if applicable *(Please Print)*

_____

Relationship of Representative to Individual *(If Applicable and Proof Required)*

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Pre-Authorized Payment Plan Request

☐ **New Plan** ☐ **Add to Existing Plan** ☐ **Change of Bank**

I want to make premium payments through the **Pre-Authorized Payment Plan**. I instruct MTL Insurance Company to make monthly withdrawals from the account I have specified and pay premiums on the policy(ies) listed. Make the deduction on the _____ of each month, beginning _____ (month/year).

Please Note: The day specified must be the 1st through the 28th **only** - if you choose the 29th, 30th, or 31st, the deduction will occur on the 28th. If a day is not specified, the deduction will be on the same day of the month as the Policy Issue Date.

Policy Number(s)

_____ _____ _____ _____

_____ _____ _____ _____

☐ Automatic Loan Repayment (ALR): Draw an additional $ _____ (minimum $25.00) each month and apply it to reduce the loan on Policy Number _____ . If this monthly payment exceeds the amount needed to repay the loan completely, the deduction will be adjusted to the payoff amount and this part of the agreement will end.

I understand and agree that:

1. The Plan will be effective when approved by the Company.
2. The Company will send no premium notices for policies on the Plan.
3. This Plan may be stopped by the Owner, the Depositor if other than the Owner, or by the Company at any time upon written notification.
4. If the Plan is terminated for any reason, premiums will be payable as provided in the policy.

_____ _____
Date Signed Depositor(s)

_____ _____
Owner (other than Depositor)

Affix Specimen Check to the Back Side of this form.

Bank Name _____

Address _____

Account Number _____ Type ☐ Checking ☐ Savings

Policy Term Conversion / Purchase Option Application

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Side A

☐ **Conversion:** This is an application to convert the Term Coverage on Policy Number _____ on the life of _____ to a new policy as stated below.

Remove any remaining Term Coverage from the original policy? ☐ Yes ☐ No

☐ **Purchase Option:** This is an application to request additional insurance on the life of _____, to be issued in accordance to the provisions of Policy Number _____, and as stated below.

Insurance Desired: $_____ face amount on the _____ plan to be dated _____, at the attained age of the Insured.

The policy provisions relating to incontestability and suicide contained in any additional or new policy shall extend from the Date of Issue of the original policy and not from the Date of Issue of such additional or new policy.

Additional Riders and Benefits:

☐ Single Premium Paid Up Insurance Rider:
☐ Face Amount or ☐ Premium $ _____

☐ Flexible Premium Paid Up Insurance Rider:
Initial Premium $ _____
Maximum Annual Premium $ _____
Stipulated Annual Premium $ _____
Years Payable _____

☐ Disability Benefit Rider: Benefit Period _____(in yrs)
Annual Benefit Amount $ _____

☐ Children Insurance $ _____

☐ Term Insurance Rider:

Proposed Insured's Name	Type	Amount

☐ Waiver of Premium - "Own Occupation" ☐ 2 yr or ☐ 5 yr
☐ Accelerated Death Benefit Rider
☐ Accidental Death Benefit $ _____
☐ _____
☐ Automatic Premium Payment Provision

Additions, that are not guaranteed per the policy provisions, are subject to evidence of insurability satisfactory to the Company. Complete Sides A, B, and the HIPAA Form. If requesting a new Proposed Insured - Complete Pages 1 and 2 of Form 6331-12.

Dividend Options
☐ Buy Paid Up Additions ☐ Apply Toward Premium ☐ Maximum Accumulation (Flexible PUA Rider required)
☐ Accumulate at Interest ☐ Buy One Year Term Only ☐ One Year Term (Equal to the cash value of the basic plan)
☐ Paid in Cash ☐ _____ ☐ One Year Term / PUA's (Modified Whole Life Plans only)

Mode of Premium Payment desired
☐ Annual ☐ Quarterly ☐ Semi-Annual
☐ Pre-Authorized Payment Plan ☐ Other: _____

Ownership: The Owner of any policy issued hereon shall be the Insured, unless otherwise stated below:

Full legal name _____ Relationship to Insured _____ Date of Birth _____
Taxpayer Identification Number* _____ ☐ Individual (SSN) ☐ Corporation ☐ Partnership ☐ Trust
Grantor of Trust (If no Trust TIN) _____ Taxpayer Identification Number _____
Street Address _____ City _____
State _____ Zip Code _____ Phone Number _____ Email _____

Contingent Owner - Upon death, the rights of the deceased Owner shall pass to the estate of the Owner, unless otherwise stated below:

Full legal name _____ Relationship to Insured: _____ Date of Birth _____
Taxpayer Identification Number* _____ ☐ Individual (SSN) ☐ Corporation ☐ Partnership ☐ Trust
Grantor of Trust (If no Trust TIN) _____ Taxpayer Identification Number _____

* If Ownership is a Trust, enter the Trust Taxpayer Identification Number. If no Trust TIN, enter Grantor's Taxpayer Identification Number.

Beneficiary Designation: Death benefit proceeds are to be paid as follows, unless changed by written request at a later date. Unless, otherwise stated, beneficiaries of the same class will share equally, with right of survivorship.

Primary
Full Legal Name _____ Relationship to Insured _____ Date of Birth _____
Street Address _____ City _____ State _____ Zip Code _____
Full Legal Name _____ Relationship to Insured _____ Date of Birth _____
Street Address _____ City _____ State _____ Zip Code _____

Contingent
Full Legal Name _____ Relationship to Insured _____ Date of Birth _____
Street Address _____ City _____ State _____ Zip Code _____
Full Legal Name _____ Relationship to Insured _____ Date of Birth _____
Street Address _____ City _____ State _____ Zip Code _____

Policy Term Conversion / Purchase Option Application

MTL Insurance Company

Side B

I hereby declare that the following statements and answers are complete and true to the best of my knowledge and belief, whether written in my own hand or not. I agree that they shall be a basis for the policy applied for under the terms of Policy Number: _____

1. Insured or Applicant
   a. Full Legal Name _____
   b. Date of Birth _____ c. Driver's License / Identification Number _____
   d. Street Address _____
   City: _____ State: _____ Zip Code: _____ Phone _____

2. Insured or Applicant Employment
   a. Occupation _____ b. Annual Earned Income $ _____
   c. Employer Name _____
   Street Address _____
   City _____ State _____ Zip Code _____

3. a. Total Insurance now in force with other companies:
   Life $_____ Accidental Death $_____ Monthly Disability Income $_____
   b. Last Policy Issued _____ (Date) by _____ (Company)

4. Has the Insured within the past five years flown in any type of aircraft as a pilot, student pilot or crew member, or does the Insured intend to do so in the next twelve months? If Yes, complete Aviation Supplement. ☐ Yes ☐ No

5. Has the Insured EVER been advised of, diagnosed, tested positive for, sought consultation for, or been treated for: cancer, stroke, or heart attack (heart disease) by a member of the medical profession? If Yes, provide details. ☐ Yes ☐ No

6. Height_____ ft._____ in. Weight _____ lbs Change in the past year _____ lbs.
   Specify whether Gain or Loss and cause: _____

7. Has the Insured used tobacco or nicotine in any form in the past 12 months? ☐ Yes ☐ No

8. Has the Insured within the past 5 years:
   a. Applied for insurance or reinstatement without receiving it exactly as requested? ☐ Yes ☐ No
   b. Applied for or received any type of sickness or disability benefits, pension, or compensation? ☐ Yes ☐ No
   If Yes, provide details _____

9. Enter name and address of personal doctor (usual medical advisor), also date and reason last consulted.
   Name _____ Street Address _____
   City _____ State _____ Zip Code _____ Phone _____
   Date _____ Reason _____

10. Has the Insured ever pled guilty to or been convicted of a felony? If Yes, provide details. ☐ Yes ☐ No

11. Has the Insured been treated, examined or advised by a member of the medical profession during the past 5 years? If Yes, provide details below. ☐ Yes ☐ No
    Reference to previous examinations for this Company is not acceptable as an answer in the following section.

Diagnosis	Date of Diagnosis	Date of Treatment	Name, Address, and Phone of Doctor

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The undersigned hereby represent(s) that the foregoing statements and answers to the best of our (my) knowledge and belief, as well as any made in continuation hereof, are complete and true, and it is agreed as follows:

1. That all of said statements and answers, including those in continuation hereof, shall constitute the application and form the basis of any policy change that may be issued;
2. That the company shall incur no liability under this application until it has been received, approved, and any necessary premium has actually been paid to and accepted by the Company, all while the health, occupation and any other conditions relating to each person to be insured are as described in this application, in which case such policy change shall take effect as of the date shown therein;
3. That if the Company should issue a policy change different from that applied for, or in the case of apparent errors or omissions discovered by the Company, the Company is hereby authorized to amend this application by "Home Office Endorsement," and the acceptance of any policy change issued on this application shall constitute an approval of the policy provisions and a ratification of such amendment. However, written consent of the Insured and the Applicant, if other than the Insured, may be required for any amendment relating to amount, classification, plan of insurance or benefits.

I/We hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health, or of any of my minor children who are to be insured, to give to MTL Insurance Company, or its reinsurer(s), any such information. This authorization shall permit the above named company, or its reinsurer(s) or its representative, and any consumer reporting agency to verify my personal information and to view, copy, be furnished copies, or be given details of: (a) medical and other history; (b) mental or physical conditions; (c) evaluation, diagnosis, treatment, and prognosis of mental or physical conditions. Such information shall specifically include psychiatric treatment and drug or alcohol abuse treatment. I authorize MTL Insurance Company or its reinsurer(s) to make a brief report of my personal health information to MIB. I understand that the MIB may exchange my personal health information for remuneration when another MIB member inquires about me. A photocopy of this authorization shall be as valid as the original. This authorization may also be used to verify current address information and shall be in effect for this purpose only until revoked. Otherwise, this authorization expires two years after the date of the policy.

I/We acknowledge receipt of the disclosure statement regarding the investigative consumer report and the MIB, and authorize MTL Insurance Company, or its reinsurer(s), to obtain a consumer investigative report if deemed necessary and to make a brief report regarding information relating to my health and insurability to the MIB.

☐ I elect to be interviewed if a consumer report is prepared in connection with this application. Please contact me between the hours of _____ and _____. Telephone number of Proposed Primary Insured _____ .

Who Must Sign: The Owner; the Insured, if other than the Owner; and any Irrevocable Beneficiary, Creditor Beneficiary, Assignee. Where the signature of a corporation is required, the name of the corporation should be filled in followed by the signature and title of an officer.

Signed at _____ Date _____
(City and State)

_____
Signature of Proposed Primary Insured (Age 15 and over)

_____
Signature of Owner (If other than Proposed Primary Insured)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Grantor (If other than Trustee)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Parent/Legal Guardian (Include Title/Relationship)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Irrevocable Beneficiary or Creditor Beneficiary

_____
Signature of Assignee

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date _____ Signature Witness (Agent) _____

Print Name _____

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This page must be given to the Primary Insured. A copy must also be given to each Additional Insured.

Disclosure Statement

Thank You for your request for a change to your policy. As part of the normal underwriting process, an investigative consumer report may be obtained. This report may include information as to your character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with you and/or friends, neighbors, and associates. Upon written request to our Policy Change Department, a summary of your rights and complete information as to the nature and scope of such report will be provided.

By use of the reports mentioned above, we are able to offer insurance coverage at the lowest possible cost to all who qualify. We appreciate the opportunity of serving your life insurance needs. We want to assure you that your application will receive the most prompt and favorable consideration possible.

Please Note that information regarding your insurability will be treated as confidential. However, MTL Insurance Company or its reinsurer(s) may make a brief report thereon to the Medical Information Bureau ("MIB"). This is a non-profit membership organization of life insurance companies. It operates an information exchange on behalf of its members. Upon request by another member insurance company, to which you have applied for life or health insurance coverage or to which a claim is submitted, the MIB will supply that company with information it may have in its files.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact the MIB. You may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734; telephone number 866-692-6901 (www.mib.com).

MTL Insurance Company or its reinsurer(s) may also release information in its file directly to other life insurance companies to which you may apply for life or health insurance or to which a claim for benefits may be submitted.

MTL Insurance Company **Oak Brook, Illinois 60523-2269**

Policy Reissue / Change Application

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Side A

This is an application to change Policy Number _____ on the life of _____ as stated below, and the policy is returned to the Company for the change.

☐ **REISSUE** *(Changes made at inception).* Allowed up to six months from the date of issue, with the return of Page 3.

☐ **CHANGE** *(Changes made after inception).* Over six months from the date of issue. Original policy will be endorsed.

Base Plan of Insurance

A change to a lower premium plan may be subject to evidence of insurability satisfactory to the Company. Complete Sides A, B, and the HIPAA Form.

Current: _____ Face Amount: _____

Proposed: _____ Face Amount: _____

☐ **Redate to** _____ *Subject to evidence of insurability if occurring more than 30 days after date of issue. Complete Sides A, B, and the HIPAA Form.*

☐ **Modification of Risk Classification** _____ *Subject to evidence of insurability satisfactory to the Company. Complete Sides A, B, and the HIPAA form.*

Riders and Benefits

Additions are subject to evidence of insurability satisfactory to the Company. Complete Sides A, B, and the HIPAA Form. If requesting a new Proposed Insured - Complete Pages 1 and 2 of Form 6331-12.

Full Pay	Add	Change	Remove	
				Traditional Life
	☐	☐	☐	Single Premium Paid Up Insurance Rider ☐ Face Amount or ☐ Premium $ _____
☐	☐	☐	☐	Annual Premium Paid Up Insurance Rider ☐ Face Amount or ☐ Premium $ _____
				☐ Convert to Flexible Premium Paid Up Insurance Rider. (Indicate any changes to the Stipulated or Maximum annual premium amounts in the Flexible Premium Paid Up Insurance Rider section.)
				☐ Convert the existing Waiver of Premium benefit to the Disability Benefit Rider. (Complete the Disability Benefit Rider information in the Flexible Premium Paid Up Insurance Rider section)
	☐	☐	☐	Flexible Premium Paid Up Insurance Rider
				Initial Premium $ _____ Maximum Annual Premium $ _____
				Stipulated Annual Premium $ _____ Years Payable _____
				☐ Disability Benefit Rider: Annual Benefit Amount $ _____ Benefit Period _____ (in yrs)
	☐		☐	Accelerated Death Benefit Rider
	☐	☐	☐	Waiver of Premium - "Own Occupation" ☐ 2 year or ☐ 5 year
				Universal Life
	☐		☐	Waiver of Monthly Deduction Rider
				Additional Riders and Benefits
	☐	☐	☐	Accidental Death $ _____
	☐	☐	☐	Children Insurance $ _____
	☐	☐	☐	Purchase Option $ _____

	Proposed Insured's Name	Type	Amount
☐ ☐ ☐	Term Insurance Rider		
☐ ☐ ☐	Term Insurance Rider		
☐ ☐ ☐			

Prevent MEC ☐ Yes ☐ No

Surrender Paid Up Additions Rider ☐ Single ☐ Annual ☐ Flexible | ☐ Full or ☐ Partial | ☐ Face Amount or ☐ Cash Value

Amount $ _____ Federal Taxes to be Withheld $ _____

Disbursement Instructions _____

Dividend Options

☐ Buy Paid Up Additions ☐ Apply Toward Premium ☐ Maximum Accumulation (Flexible PUA Rider required)

☐ Accumulate at Interest ☐ Buy One Year Term Only ☐ One Year Term (Equal to the cash value of the basic plan)

☐ Paid in Cash ☐ _____ ☐ One Year Term/PUA's (Modified Whole Life Plans only)

Mode of Premium Payment desired ☐ Annual ☐ Quarterly ☐ Semi-Annual ☐ Pre-Authorized Payment Plan ☐ Other _____

Policy Reissue / Change Application

MTL Insurance Company

Side B

I hereby declare that the following statements and answers are complete and true to the best of my knowledge and belief, whether written in my own hand or not. I agree that they shall be a basis for the policy reissue / change applied for under the terms of Policy Number: _____

1. Insured or Applicant
   a. Full Legal Name _____
   b. Date of Birth _____ c. Driver's License / Identification Number _____
   d. Street Address _____
   City: _____ State: _____ Zip Code: _____ Phone _____

2. Insured or Applicant Employment
   a. Occupation _____ b. Annual Earned Income $ _____
   c. Employer Name _____
   Street Address _____
   City _____ State _____ Zip Code _____

3. a. Total Insurance now in force with other companies:
   Life $_____ Accidental Death $_____ Monthly Disability Income $_____
   b. Last Policy Issued _____ by _____
   Date Company

4. Has the Insured within the past five years flown in any type of aircraft as a pilot, student pilot or crew member, or does the Insured intend to do so in the next twelve months? If Yes, complete Aviation Supplement. ☐ Yes ☐ No

5. Has the Insured EVER been advised of, diagnosed, tested positive for, sought consultation for, or been treated for: cancer, stroke, or heart attack (heart disease) by a member of the medical profession? If Yes, provide details. ☐ Yes ☐ No

6. Height_____ ft._____ in. Weight _____ lbs Change in the past year _____ lbs.
   Specify whether Gain or Loss and cause: _____

7. Has the Insured used tobacco or nicotine in any form in the past 12 months? ☐ Yes ☐ No

8. Has the Insured within the past 5 years:
   a. Applied for insurance or reinstatement without receiving it exactly as requested? ☐ Yes ☐ No
   b. Applied for or received any type of sickness or disability benefits, pension, or compensation? ☐ Yes ☐ No
   If Yes, provide details _____

9. Enter name and address of personal doctor (usual medical advisor), also date and reason last consulted.
   Name _____ Street Address _____
   City _____ State _____ Zip Code _____ Phone _____
   Date _____ Reason _____

10. Has the Insured ever pled guilty to or been convicted of a felony? If Yes, provide details. ☐ Yes ☐ No

11. Has the Insured been treated, examined or advised by a member of the medical profession during the past 5 years? If Yes, provide details below. ☐ Yes ☐ No
    Reference to previous examinations for this Company is not acceptable as an answer in the following section.

Diagnosis	Date of Diagnosis	Date of Treatment	Name, Address, and Phone of Doctor

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The undersigned hereby represent(s) that the foregoing statements and answers to the best of our (my) knowledge and belief, as well as any made in continuation hereof, are complete and true, and it is agreed as follows:

1. That all of said statements and answers, including those in continuation hereof, shall constitute the application and form the basis of any policy change that may be issued;
2. That the company shall incur no liability under this application until it has been received, approved, and any necessary premium has actually been paid to and accepted by the Company, all while the health, occupation and any other conditions relating to each person to be insured are as described in this application, in which case such policy change shall take effect as of the date shown therein;
3. That if the Company should issue a policy change different from that applied for, or in the case of apparent errors or omissions discovered by the Company, the Company is hereby authorized to amend this application by "Home Office Endorsement," and the acceptance of any policy change issued on this application shall constitute an approval of the policy provisions and a ratification of such amendment. However, written consent of the Insured and the Applicant, if other than the Insured, may be required for any amendment relating to amount, classification, plan of insurance or benefits.

I/We hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health, or of any of my minor children who are to be insured, to give to MTL Insurance Company, or its reinsurer(s), any such information. This authorization shall permit the above named company, or its reinsurer(s) or its representative, and any consumer reporting agency to verify my personal information and to view, copy, be furnished copies, or be given details of: (a) medical and other history; (b) mental or physical conditions; (c) evaluation, diagnosis, treatment, and prognosis of mental or physical conditions. Such information shall specifically include psychiatric treatment and drug or alcohol abuse treatment. I authorize MTL Insurance Company or its reinsurer(s) to make a brief report of my personal health information to MIB. I understand that the MIB may exchange my personal health information for remuneration when another MIB member inquires about me. A photocopy of this authorization shall be as valid as the original. This authorization may also be used to verify current address information and shall be in effect for this purpose only until revoked. Otherwise, this authorization expires two years after the date of the policy.

I/We acknowledge receipt of the disclosure statement regarding the investigative consumer report and the MIB, and authorize MTL Insurance Company, or its reinsurer(s), to obtain a consumer investigative report if deemed necessary and to make a brief report regarding information relating to my health and insurability to the MIB.

☐ I elect to be interviewed if a consumer report is prepared in connection with this application. Please contact me between the hours of _____ and _____. Telephone number of Proposed Primary Insured _____ .

Who Must Sign: The Owner; the Insured, if other than the Owner; and any Irrevocable Beneficiary, Creditor Beneficiary, Assignee. Where the signature of a corporation is required, the name of the corporation should be filled in followed by the signature and title of an officer.

Signed at _____ Date _____
(City and State)

_____
Signature of Proposed Primary Insured (Age 15 and over)

_____
Signature of Owner (If other than Proposed Primary Insured)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Grantor (If other than Trustee)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Parent/Legal Guardian (Include Title/Relationship)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Irrevocable Beneficiary or Creditor Beneficiary

_____
Signature of Assignee

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date _____ Signature Witness (Agent) _____

Print Name _____

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This page must be given to the Primary Insured. A copy must also be given to each Additional Insured.

Disclosure Statement

Thank You for your request for a change to your policy. As part of the normal underwriting process, an investigative consumer report may be obtained. This report may include information as to your character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with you and/or friends, neighbors, and associates. Upon written request to our Policy Change Department, a summary of your rights and complete information as to the nature and scope of such report will be provided.

By use of the reports mentioned above, we are able to offer insurance coverage at the lowest possible cost to all who qualify. We appreciate the opportunity of serving your life insurance needs. We want to assure you that your application will receive the most prompt and favorable consideration possible.

Please Note that information regarding your insurability will be treated as confidential. However, MTL Insurance Company or its reinsurer(s) may make a brief report thereon to the Medical Information Bureau ("MIB"). This is a non-profit membership organization of life insurance companies. It operates an information exchange on behalf of its members. Upon request by another member insurance company, to which you have applied for life or health insurance coverage or to which a claim is submitted, the MIB will supply that company with information it may have in its files.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact the MIB. You may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734; telephone number 866-692-6901 (www.mib.com).

MTL Insurance Company or its reinsurer(s) may also release information in its file directly to other life insurance companies to which you may apply for life or health insurance or to which a claim for benefits may be submitted.

MTL Insurance Company **Oak Brook, Illinois 60523-2269**

Policy
Reissue / Change
Supplemental Application

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This Supplement is Part of the Application on the life of _____ Policy Number _____
(Primary Insured's Name)

For a Policy with: ☐ Term Rider Insurance ☐ Children Insurance ☐ Applicant Waiver of Premium

1. Persons Proposed for Coverage (Please Print)

Full Legal Name (First, Middle Initial, Last)	Occupation	Social Security Number	Relationship to Primary Insured	State of Birth	Date of Birth mm/dd/yyyy	Age Nearest Birthday	Sex	Marital Status	Height Ft.	Height In.	Weight
a.											
b.											
c.											
d.											
e.											

2. Does any Proposed Insured have any existing individual life insurance or annuity contracts in force? ☐ Yes ☐ No
(If Yes, give details below)

Name of Proposed Insured	Company Name	Policy Number	Amount	Year Issued	Accidental Death Amount	Annuity	Business Insurance
a.						☐	☐
b.						☐	☐
c.						☐	☐
d.						☐	☐
e.						☐	☐

3. Are all Proposed Insureds citizens of the U.S.A.? If No, provide details, name of person, and the present status. ☐ Yes ☐ No

4. Has any Proposed Insured ever pled guilty to or been convicted of a felony? If Yes, provide details. ☐ Yes ☐ No

5. Beneficiary Designation: Death benefit proceeds are to be paid as follows, unless changed by written request at a later date. Complete address information if other than Primary Insured's address.

Beneficiary(ies) for Insured _____

Primary Full Legal Name _____ Relationship to Insured _____ Date of Birth _____
Street Address _____ City _____ State _____ Zip Code _____

Contingent Full Legal Name _____ Relationship to Insured _____ Date of Birth _____
Street Address _____ City _____ State _____ Zip Code _____

Beneficiary(ies) for Insured _____

Primary Full Legal Name _____ Relationship to Insured _____ Date of Birth _____
Street Address _____ City _____ State _____ Zip Code _____

Contingent Full Legal Name _____ Relationship to Insured _____ Date of Birth _____
Street Address _____ City _____ State _____ Zip Code _____

Unless stated differently above:

- Any Additional Insured's death benefit shall be paid to the Primary Insured if living; if not living, to the estate of the Additional Insured.
- Any Children Insurance Rider death benefit shall be paid to the Primary Insured, if living; if not living, to the Primary Insured's legal Spouse as of the date of death of the Primary Insured, if living; if no spouse, or if not living, to the estate of such Child.
- Beneficiaries of the same class will share equally with the right of survivorship. If a Trustee is named above, payment to such Trustee will discharge the Company from further liability to the extent of that payment.

This Supplement is Part of the Application on the life of: _____

Proposed Insured's Name: _____

Complete a separate page for each Proposed Insured Or if applying for Owner/Applicant Waiver of Premium

(Circle all applicable items and provide details for all "YES" answers in Question 13.)

	Yes	No
6. Has the Proposed Insured EVER been advised of, diagnosed, tested positive for, sought consultation for, or been treated for: cancer, stroke or heart attack (heart disease) by a member of the medical profession?	☐	☐
7. Has the Proposed Insured, within the past 10 years, been advised of, diagnosed, tested positive for, sought consultation for, or been treated by a member of the medical profession, for:		
a. Convulsions, seizures, paralysis, mental or nervous disorder, attempted suicide, or recurrent dizziness, fainting or headaches?	☐	☐
b. Asthma, emphysema, tuberculosis, bronchitis or chronic respiratory disorder, sleep apnea or persistent shortness of breath?	☐	☐
c. Chest pain or tightness, palpitations, high blood pressure, heart murmur, other disorder of the heart or blood vessels?	☐	☐
d. Hepatitis, intestinal bleeding, ulcer, colitis, recurrent diarrhea or indigestion, or other disorder of the stomach, intestines, liver or pancreas?	☐	☐
e. Sugar, albumin, blood or pus in urine, venereal disease or other disorder of kidney, bladder, prostate, breasts or reproductive organs?	☐	☐
f. Diabetes, thyroid or other endocrine disorders?	☐	☐
g. Arthritis, or disorder of the muscles, bones, spine, back or joints?	☐	☐
h. Disorder of the skin, lymph glands, cyst or tumor?	☐	☐
i. Disorder of the eyes, anemia or other disorder of the blood?	☐	☐
8. Has the Proposed Insured, within the past 10 years, been medically diagnosed or treated by a physician as having AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or any other immunological disorder?	☐	☐
9. Has the Proposed Insured within the past 10 years:		
a. Used barbiturates, heroin, cocaine, marijuana, or any other illegal or controlled substance, except as prescribed by a physician?	☐	☐
b. Been advised to seek, or received counseling or treatment, or attended or joined any organization for alcohol or drug dependence?	☐	☐
10. Other than above, has the Proposed Insured within the past 5 years:		
a. Been diagnosed or treated for a mental or physical disorder, illness, injury or surgery?	☐	☐
b. Had a checkup or other consultation?	☐	☐
c. Been a patient in a hospital, clinic, medical center or other medical facility?	☐	☐
d. Had an EKG, stress test or any other diagnostic test (not including HIV tests)?	☐	☐
e. Been advised to have any diagnostic test (not including HIV tests), hospitalization or surgery which was not completed?	☐	☐
f. Requested or received a pension, benefits, or payment because of an injury, sickness or disability?	☐	☐
11. Has the Proposed Insured:		
a. Lost or gained more than 15 lbs in the past year? If Yes, indicate reason and amount of gain or loss.	☐	☐
b. Used tobacco or nicotine in any form in the past 12 months?	☐	☐
c. Used tobacco or nicotine in any form in the past 48 months?	☐	☐
12. Is the Proposed Insured currently under observation by a physician or taking any prescription medication(s)?	☐	☐

13. Details of "YES" answers. ***Identify question number and include***: Diagnoses, prescription medication(s), dates, duration, and name and addresses of all attending physicians and medical facilities.

Question	Details

14. Primary Care Physician: Name: _____ Phone Number: _____

Address: _____

15. Proposed Insured Family History:

	Yes	No
a. Has any family member been diagnosed with diabetes, cancer, stroke, heart or kidney disease or mental illness? (If Yes, give details including date of diagnosis)	☐	☐

b.

	Age if Living	Cause of Death	Age at Death		Number Living	Number Deceased	Cause of Death	Age at Death
Father				Brothers				
Mother				Sisters				

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1. That all of said statements and answers, including those in continuation hereof, shall constitute the application and form the basis of any policy change that may be issued;
2. That the company shall incur no liability under this application until it has been received, approved, and any necessary premium has actually been paid to and accepted by the Company, all while the health, occupation and any other conditions relating to each person to be insured are as described in this application, in which case such policy change shall take effect as of the date shown therein;
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I/We hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health, or of any of my minor children who are to be insured, to give to MTL Insurance Company, or its reinsurer(s), any such information. This authorization shall permit the above named company, or its reinsurer(s) or its representative, and any consumer reporting agency to verify my personal information and to view, copy, be furnished copies, or be given details of: (a) medical and other history; (b) mental or physical conditions; (c) evaluation, diagnosis, treatment, and prognosis of mental or physical conditions. Such information shall specifically include psychiatric treatment and drug or alcohol abuse treatment. I authorize MTL Insurance Company or its reinsurer(s) to make a brief report of my personal health information to MIB. I understand that the MIB may exchange my personal health information for remuneration when another MIB member inquires about me. A photocopy of this authorization shall be as valid as the original. This authorization may also be used to verify current address information and shall be in effect for this purpose only until revoked. Otherwise, this authorization expires two years after the date of the policy.

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☐ I elect to be interviewed if a consumer report is prepared in connection with this application. Please contact me between the hours of _____ and _____. Telephone number of Proposed Primary Insured _____ .

Who Must Sign: The Owner; the Insured, if other than the Owner; and any Irrevocable Beneficiary, Creditor Beneficiary, Assignee. Where the signature of a corporation is required, the name of the corporation should be filled in followed by the signature and title of an officer.

Signed at _____ Date _____
(City and State)

_____
Signature of Proposed Primary Insured (Age 15 and over)

_____
Signature of Owner (If other than Proposed Primary Insured)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Grantor (If other than Trustee)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Parent/Legal Guardian (Include Title/Relationship)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Irrevocable Beneficiary or Creditor Beneficiary

_____
Signature of Assignee

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date _____ Signature Witness (Agent) _____

Print Name _____

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Disclosure Statement

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MTL Insurance Company or its reinsurer(s) may also release information in its file directly to other life insurance companies to which you may apply for life or health insurance or to which a claim for benefits may be submitted.

MTL Insurance Company **Oak Brook, Illinois 60523-2269**

Policy Reinstatement Application

MTL INSURANCE COMPANY®
A member of the MUTUAL TRUST FINANCIAL GROUP
1200 Jorie Boulevard • Oak Brook, Illinois 60523-2269
Toll Free: 1-800-323-7320 • www.mutualtrust.com

Application is hereby made to MTL Insurance Company for reinstatement of Policy Number: _____

1. Insured a. Name _____
   b. Date of Birth _____ c. Driver's License/Identification Number _____
   d. Street Address _____
   City _____ State _____ Zip Code _____ Phone _____

2. Insured Employment a. Occupation _____ b. Annual Earned Income $ _____
   c. Employer Name _____
   Street Address _____
   City _____ State _____ Zip Code _____

3. Has the Insured within the past 5 years:
   a. Applied for insurance or reinstatement without receiving it exactly as requested? ☐ Yes ☐ No
   b. Applied for or received any type of sickness or disability benefits, pension, or compensation? ☐ Yes ☐ No
   If Yes, provide details.

4. Has the Insured EVER been advised of, diagnosed, tested positive for, sought consultation for, or been treated for: cancer, stroke, or heart attack (heart disease) by a member of the medical profession? If Yes, provide details. ☐ Yes ☐ No

5. Is the Insured under any kind of treatment or on a restricted diet for any complaint or cause? If Yes, provide details. ☐ Yes ☐ No

6. Insured: Height _____ ft. _____ in. Weight _____ lbs Change in the past year: _____ lbs.
   Specify whether Gain or Loss and cause:

7. Has the Insured used tobacco or nicotine in any form in the past 12 months? ☐ Yes ☐ No

8. Has the Insured been treated, examined or advised by a member of the medical profession during the past 5 years? ☐ Yes ☐ No
   If Yes, provide details.

Diagnosis	Date of Diagnosis	Dates of Treatment	Name, Address, and Phone of Doctor

9. Has the Insured within the past five years flown in any type of aircraft as a pilot, student pilot or crew member, or does the Insured intend to do so in the next twelve months? If Yes, complete Aviation Supplement. ☐ Yes ☐ No

10. Has the Insured ever pled guilty to or been convicted of a felony? If Yes, provide details. ☐ Yes ☐ No

If this application is for reinstatement of a policy containing insurance protection on family members, Question 11 must be answered.

11. Have any family members, Spouse or Dependent Children, listed in the application for this policy been treated, examined or advised by a member of the medical profession during the past 5 years? If Yes, provide details. ☐ Yes ☐ No

12. If you had a premium paying rider at the time of lapse, would you like it reinstated? If Yes, please list riders to reinstate. ☐ Yes ☐ No

_____

_____

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The undersigned hereby represent(s) that the foregoing statements and answers to the best of our (my) knowledge and belief, as well as any made in continuation hereof, are complete and true, and it is agreed as follows:

1. That all of said statements and answers, including those in continuation hereof, shall constitute the application and form the basis of any policy change that may be issued;
2. That the company shall incur no liability under this application until it has been received, approved, and any necessary premium has actually been paid to and accepted by the Company, all while the health, occupation and any other conditions relating to each person to be insured are as described in this application, in which case such policy change shall take effect as of the date shown therein;
3. That if the Company should issue a policy change different from that applied for, or in the case of apparent errors or omissions discovered by the Company, the Company is hereby authorized to amend this application by "Home Office Endorsement," and the acceptance of any policy change issued on this application shall constitute an approval of the policy provisions and a ratification of such amendment. However, written consent of the Insured and the Applicant, if other than the Insured, may be required for any amendment relating to amount, classification, plan of insurance or benefits.

I/We hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health, or of any of my minor children who are to be insured, to give to MTL Insurance Company, or its reinsurer(s), any such information. This authorization shall permit the above named company, or its reinsurer(s) or its representative, and any consumer reporting agency to verify my personal information and to view, copy, be furnished copies, or be given details of: (a) medical and other history; (b) mental or physical conditions; (c) evaluation, diagnosis, treatment, and prognosis of mental or physical conditions. Such information shall specifically include psychiatric treatment and drug or alcohol abuse treatment. I authorize MTL Insurance Company or its reinsurer(s) to make a brief report of my personal health information to MIB. I understand that the MIB may exchange my personal health information for remuneration when another MIB member inquires about me. A photocopy of this authorization shall be as valid as the original. This authorization may also be used to verify current address information and shall be in effect for this purpose only until revoked. Otherwise, this authorization expires two years after the date of the policy.

I/We acknowledge receipt of the disclosure statement regarding the investigative consumer report and the MIB, and authorize MTL Insurance Company, or its reinsurer(s), to obtain a consumer investigative report if deemed necessary and to make a brief report regarding information relating to my health and insurability to the MIB.

☐ I elect to be interviewed if a consumer report is prepared in connection with this application. Please contact me between the hours of _____ and _____. Telephone number of Proposed Primary Insured _____ .

Who Must Sign: The Owner; the Insured, if other than the Owner; and any Irrevocable Beneficiary, Creditor Beneficiary, Assignee. Where the signature of a corporation is required, the name of the corporation should be filled in followed by the signature and title of an officer.

Signed at _____ Date _____
(City and State)

_____
Signature of Proposed Primary Insured (Age 15 and over)

_____
Signature of Owner (If other than Proposed Primary Insured)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Grantor (If other than Trustee)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Parent/Legal Guardian (Include Title/Relationship)

_____
Signature of Other Proposed Insured (Age 15 and over)

_____
Signature of Irrevocable Beneficiary or Creditor Beneficiary

_____
Signature of Assignee

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date _____ Signature Witness (Agent) _____

Print Name _____

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